Clinical Remarks
ON
SOFTENING OF THE CRUS CEREBRI AND PONS, AND ON SYPHILITIC DISEASE OF THE CEREBRAL ARTERIES.

Delivered at St. Thomas's Hospital,

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GENTLEMEN,—The four cases to which I wish to call attention present, each of them, individual points of interest; but doubtless their chief value resides in the fact that they have a close pathological and clinical relationship. They are all of them cases of softening of the pons Varolii, or crus cerebri, and adjacent parts. The symptoms were in all cases those of what is roughly termed cross paralysis, and in every instance the affection was ushered in by premonitory symptoms. The symptoms, however, presented considerable differences of detail, and there were differences as regards etiology.

The first case is that of a young man who had contracted a chancre exactly six months before his death, and who was suffering from secondary symptoms in the form of psoriasis at the time when his fatal illness seized him. The symptoms of this illness began five or six weeks before he died (and certainly therefore within five months of his syphilitic inoculation) with occipital headache and sickness. After three or four weeks, or, more exactly, fourteen days before his death, he began to ramble a little in his mind and to be troublesome; and the next morning it was noticed that his pupils were contracted, his conjunctivæ congested, and his left eyelid a little dropped. Five days later, when he woke in the morning, he was found to be hemiplegic on the left side; and after another four days it was noticed not only that the left eyelid was a little dropped, but that there was paralysis of all the muscles of the right eye, excepting probably the superior oblique. Meanwhile the patient was becoming more and more drowsy and stupid, and he died quietly on the fourth day after the paralysis of the muscles of the right eye had declared itself. Syphilitic disease of the internal organs generally arises as a part of the so-called "tertiary symptoms" of syphilis, and therefore late in the progress of the disease, and often after many years have elapsed. Still, as the patient here appeared to have been in all other respects a healthy man, it was assumed during life that his cerebral affection was syphilitic, and he was treated accordingly. Further, it was not difficult to speculate, from the symptoms, as to whereabouts the cerebral lesion would be found. The left-sided hemiplegia pointed to involvement of the motor tract, issuing from the right hemisphere of the brain; and that the part directly implicated was the right crus cerebri or the contiguous portion of the pons had been foreshadowed by the slight ptosis observed in the left upper eyelid. This surmise was confirmed when, a few days subsequently to the occurrence of hemiplegia, total paralysis of the right third nerve was added to the other phenomena. At the post-mortem examination there was found syphilitic thickening, with obstruction, of the right posterior cerebral artery, and consequent softening, with more or less disintegration in patches, of the right crus cerebri, and of some of the neighbouring parts to which this artery is distributed. The paralysis of the right sixth was no doubt due to the thickening of the membranes observed at the base of the brain, and the very partial affection of the left third was probably connected with some special but concurrent lesion of that nerve. It may be assumed, that the patient's early and comparatively vague cerebral symptoms were due to the disease of the arterial walls and slight associated inflammation of the membranes in the neighbourhood; that the hemiplegia took place when the channel of the posterior cerebral became suddenly occluded; and that the right third nerve got involved as the area of softening extended.

The second case was also that of a young man who had somewhat recently contracted syphilis, but who gave no history of having suffered from secondary symptoms. The duration of his fatal illness was between four and five weeks. For three weeks he complained of frontal headache, unattended with sickness or other important symptoms, at the end of which time he was seized during the night with almost complete left hemiplegia, associated with rigidity of the arm and leg, inability to speak, and well-marked paralysis of the third nerve on the same side. On the next day he had attacks of partial unconsciousness, during which the head and eyes were strongly turned to the left. On the following day he manifested some return of the power of articulation, and was evidently not aphasic. All signs of paralysis of the left third, seventh, and ninth nerves had disappeared, and the paralysed arm and leg had become limp. Three days later the urine, which from the beginning had had to be drawn off with a catheter, had become alkaline and offensive, and there were manifest signs of cystitis; and on that day his temperature reached 103·4°. After this the pulse increased in frequency, the temperature rose irregularly, and on one occasion he had a prolonged rigor; there was a slight return of the paralysis of the left third, seventh, and ninth, and the left arm and leg again got rigid; he passed into a state of coma, and at the time of death the temperature in his axilla had risen to 109·2°. In this case, as in the former, there was reason to suspect the presence of some syphilitic lesion of the brain, and the sudden occurrence of left hemiplegia during its progress, pointed to the direct and sudden involvement of the motor tract in, or issuing from, the right cerebral hemisphere. The partial paralysis of the third nerve on the same side as the hemiplegia seemed to show that the lesion was situated somewhere about the crus cerebri or pons; and that the pons was the actual seat of disease was to some extent confirmed by the attacks of partial unconsciousness, with turning of the head and conjugate deviation of the eyes towards the paralysed side, which occurred on the second day of his hemiplegia. It will be recollected that deviation of the eyes and head in cases of cerebral disease is towards the lesion and away from the paralysed side, while it has been observed that, at any rate occasionally, when such deviation shows itself in affections of the pons the direction of the deviation is reversed. The post-mortem examination to some extent confirmed the inferences that might have been, and in a measure were, drawn from the symptoms. There was syphilitic disease of the posterior cerebral and of some of the smaller arteries in the neighbourhood; and there was pulpy softening of the right half of the pons. No distinct occlusion of vessels was discovered; but there can be little doubt, I think, that the breaking down of tissue, which was exactly of the same kind as in the former case, and such as one meets with when arteries are obstructed, was the result of obstruction of the small arteries distributed to the softened region.

In this case, as in the other, the cause of the partial paralysis of the third nerve on the same side as the hemiplegia is not clearly explained by the obvious position of the lesion. But the difficulty of articulation which the patient manifested, and the retention of urine with tendency to rapid inflammation of the bladder, had doubtless some relation to the seat of disease. The extremely high temperature which was reached on the approach of death is a noteworthy feature in the case.

The third case was that of a man of middle age who was said to have been temperate and healthy, and never to have had syphilis. His illness began about twelve weeks before death, of which the last seven weeks and a half were spent in hospital. The onset seems to have been a kind of rigor; on which followed persistent headache and giddiness. The first definite sign of brain disease was the occurrence of double vision four days before admission, and the second left hemiplegia, which supervened on the morning of admission. When he came under observation it was found that he had partial paralysis of the right external rectus, and nystagmus of the right eye when trying to look to the right, incomplete left hemiplegia, and unsteadiness of gait. He rapidly got worse, and after four or five days it was observed that his intelligence had become affected, and that he was emotional, that his hemiplegia had become more complete, that the left internal rectus as well as the right external rectus were paralysed, and that all movements of the eyeballs, excepting that to the left, were attended with nystagmus. He had no optic neuritis. During the following two or three weeks the symptoms underwent little change; but about three or four weeks before his death partial paralysis

of the right seventh and ninth was observed for the first time, and he presented also some difficulty of speech and of swallowing. There was no manifest increase of paralysis after this; but he gradually became more and more feeble-minded, and at length comatose. Before death his temperature rose to 103·2°, his pulse to 160, and his respiration to 72 in the minute. In this case there was no evidence of syphilis; but the occurrence of paralysis of the right external rectus with left hemiplegia pointed pretty clearly to mischief about the pons, right crus, or the immediate neighbourhood of these parts. And this inference was confirmed when, later, paralysis of the left internal rectus, and still later partial paralysis of the seventh and ninth nerves on the right side, and difficulty of speech and deglutition, supervened. The post-mortem examination revealed softening in about exactly the same situation as in the first case. There was only a little atheroma in the vessels at the base of the brain; there was no sign of syphilitic disease, and no recognised obstruction of vessels. The softening, however, was in the domain of the right posterior cerebral artery, and as there was no trace of present or bygone hæmorrhage it seems probable, at least to me, that the softening was the consequence of thrombosis of some of the smaller branches of the artery just named. It is not easy to understand from the post-mortem facts of the case the cause of the paralysis of the left internal rectus or of the right seventh and ninth nerves. It is noticeable that in this case there was nystagmus, and that in this case, as in the last, there was considerable rise of temperature as death approached.

The last case occurred in the practice of my colleague, Dr. Stone. It was one of thrombotic plugging of the anterior part of the basilar artery, followed by softening of the corresponding region of the pons. The limits of the softening are not defined with precision in the post-mortem record, but the symptoms were those of interruption of the motor tract on the right side, together with much impairment of articulation. It is curious that scarcely any symptoms were present in this case to indicate the exact seat of mischief. It is probable, however, that paralysis of one or other of the cerebral nerves would have appeared had not the patient's life been cut short by his pulmonary complication.

Before proceeding to the detailed account of my cases there are a few points of more or less interest in connexion with them, mainly as a group, to which I may briefly refer. 1st. In no case was there any obvious impairment of common sensation or involvement of any of the nerves of special sense. 2nd. In no case did the patient suffer from convulsions. In one, however, there were, for one day, attacks of partial unconsciousness, attended with deviation of the head and eyes towards the paralysed side. 3rd. There was absence of optic neuritis, at any rate during a considerable period of the patient's illness, in my third case, and I believe the same fact was observed in the second, but the record of it has not been preserved. 4th. The affection of the motor nerves at the base of the brain was different in the different cases, and varied to some extent even in the same case; and, moreover, the paralysis was by no means generally most pronounced in those nerves which, judging from the seat of obvious lesion, might have been expected to be the chief sufferers. Several explanations of this phenomenon suggest themselves. Thus, the primary embarrassment of circulation may have involved a wider area than the subsequent softening, and nerve-nuclei at first implicated may have become reinstated; or, again, when necrosial softening had involved a certain district it may either have extended or, acting as a foreign body, may have excited inflammation in the circumambient parts, and so have brought additional nerve-nuclei within its influence; and, further, it is well known that most of the motor nerves at the base of the brain, and more especially, perhaps, the sixth, are liable to be interfered with either by the effects of basal meningitis, or by direct pressure exerted by a superincumbent tumour or swelling. The cases show, however, that valuable as paralysis of these nerves is as a guide to us in the diagnosis of the seat of intra-cranial lesions, their indications require to be read with care, and we cannot safely attach specific value to them indiscriminately. It may be added that in one of my cases there was paralysis of the right external rectus, which might have been expected from the seat of lesion, and also of the left internal rectus, of which the cause was not apparent. It seems probable that in this instance there was implication of the centre, which coördinates the actions of these muscles.

Secondary Syphilis; Disease of Right Posterior Cerebral Artery and Softening of Right Crus Cerebri, Optic Thalamus, &c.; Left Hemiplegia; Paralysis of Right Ocular Muscles.—F. M. W. B——, aged thirty-three, an attendant at a lunatic asylum, was admitted on April 16th, 1872. It was stated that he had had primary syphilis in the previous October, and that this had been followed by sore-throat and psoriasis. He had been treated for his complaint, I believe, with iodide of potassium and mercury, and under the influence of treatment his symptoms had gradually subsided, but not disappeared. In all other respects his health had been good up to three or four weeks before admission. He then complained of headache, chiefly occipital, which was followed in a week or ten days by vomiting, coming on for the most part directly or very shortly after meals. These symptoms have been persistent since their first appearance. He has had no pain in the chest or between the shoulders either after food or at any other time, but his appetite has been bad and his bowels constipated. He has had no cough. On admission he was still complaining of occipital headache; his tongue was thickly coated, but no disease of any important organ could be detected. The heart- and lung-sounds were healthy, the urine free from albumen, and with a specific gravity of 1027. The limbs, trunk, and especially the face, presented abundant traces of syphilitic psoriasis.—17th: Has slept badly, but has not been sick; has had much headache. There is no affection of any of the organs of sense, and he is perfectly rational. Tongue very thickly coated, white. Pulse 52; temperature 99°; bowels not open.—18th: Seems better, but has much headache, and slept badly. Temperature 99°.—20th: Has been twice sick since the last visit, has slept badly, and has rambled a little both day and night. Last night he got out of bed and tried to get into one on the opposite side of the ward, and he threw a spoon at the nurse. He speaks quite rationally when answering questions, but does not know where he is, and rambles a little when left to himself. He complains very much of headache, which appears to be general. He can see with both eyes, but complains of muscæ. Both pupils are contracted, but the right is most so, and seems to act less perfectly than the other. Both conjunctivæ are congested, especially the left. The muscles of the eyeballs act normally, but the left upper eyelid seems a little dropped. Tongue less thickly coated than it was; appetite bad; pulse 50. No indications of thoracic mischief, or of renal affection.—24th: No material change. He had thirty grains of chloral hydrate last night, slept well, and is very drowsy this morning. Says he feels better, but that his head is painful. Tongue much furred; bowels confined; pulse 54.—25th: Had a tolerably quiet night, but this morning it was noticed that he had paralysis of the left side of the body. Neither himself nor the nurse could give any account of its coming on. He cannot now move arm or leg; but sensation appears to be unimpaired in them, and reflex movements are readily excited. The mouth is drawn to the right, and the tongue deviates slightly to the left. There is no change for the worse in any of his organs of sense. He is fairly sensible, and answers questions pretty readily. Complains of pain across forehead, in back of head, and in neck. Pulse 68.—27th: Has slept pretty well the last night or two. Complains of headache still. Paralysis continues unchanged. Has had no sickness lately, and the bowels have been confined since the 25th, since when he has passed his urine into the bed. Conjunctivæ congested; pupils contracted. Tongue furred. Pulse 56.—29th: No improvement. Is certainly more dull and stupid than he was. The tongue still distinctly deviates to the left. There is no change in the condition of his pupils, but their axes now do not correspond. The left eye seems to move freely and perfectly; but the right moves neither upwards, nor inwards, nor outwards; the only movement which it executes is downwards, with an inclination to the right.—May 1st: Now takes no notice of anything that is said to him. The left upper eyelid droops more than the right; but the muscles of the right eye are paralysed. The pupils are equal and somewhat contracted. He does not appear to see. Water passed into the bed. Pulse 60.—2nd: Was very quiet all last night, and now takes no notice whatever, however loudly he is addressed. He lies on his back with the eyes closed, and when the lids are raised the right eye is seen to be directed straight forwards, the left pointing downwards and to the left. The former is quite motionless, but the left is occasionally brought into the same position as the right. He does not follow or appear to notice the light of a candle however near it is brought to the eyes, nor does the light affect the pupils, which are as nearly

equal as possible, and somewhat dilated. He breathes gently and noiselessly, and occasionally rubs his eyes with his right hand. He has had no convulsive attacks. Pulse 96. The syphilitic eruption has improved since admission, but it is still quite apparent. His death took place next morning.

Autopsy.—There is slight thickening of the membranes at the base of the brain, but no noticeable flattening or congestion of the general surface. The right posterior cerebral artery for about an inch of its length is considerably thickened and slightly translucent, and the channel of the vessel, which is much narrowed, is occluded by a tough, adherent, cylindrical, fibrinous coagulum. All the other vessels are healthy. A tract of softening involves the right crus cerebri, the outer part of the right optic thalamus and internal capsule, and the brain substance to the outer side of the hippocampus major; and patches of disintegration are present in each of these situations. The third nerve of the left side is enlarged. There is a great deal of effusion into the lateral ventricles. All other parts of the brain are healthy. Thoracic and abdominal viscera all healthy. No syphilitic disease of any of these organs.

Acute Softening of Right Half of Pons Varolii; Left Hemiplegia; Partial Paralysis of Left Third Nerve, &c.; Coma and Great Rise of Temperature before Death.—James P——, a gardener, aged twenty-seven, came under my care on Dec. 24th, 1881. Has been of loose habits and has drunk a good deal, and about two years ago had an attack of syphilis. Has had no other illness of importance. For three weeks he has complained of pain in the frontal region, which has become more severe during the last two days, and has been attended with loss of appetite; no sickness. He went to bed on the night of the 23rd fairly well but for his persistent headache. At 5.30 the next morning his brother found him lying on the floor, and thought he was drunk; he was partially insensible, and when he was being replaced in bed the brother noticed that he struggled only with one side. He was admitted into the hospital a few hours afterwards. At that time he was partially unconscious; the pupils were dilated and equal; there was an external squint of the left eye, and ptosis of the left eyelid; the upward movement of this eye also was a little impaired; the mouth appeared to be drawn slightly to the right, and the tongue was protruded markedly to the left; he was unable to speak, but seemed to understand what was said to him, and complained of pain in the frontal region; no difficulty of swallowing; the left arm was flexed at the elbow and lay across the chest; the hand also was closed; the whole limb was rigid and completely paralysed; the left leg also was rigid, but extended, and he retained slight power over the movement of the toes; the patellar reflex was brisk in both legs, but chiefly in the left; no ankle clonus; plantar reflex almost absent in the left side; left leg colder than the right; no loss or impairment of sensation; thoracic and abdominal viscera healthy. Pulse 90.—25th: Was very restless during the night, and to-day is much the same as yesterday; paralytic phenomena remain unchanged; he is unable to speak, but evidently understands what is said to him; the water has to be drawn off; he has had occasional attacks of increased, but still incomplete, unconsciousness, during which the head and both eyes were turned strongly to the left.—26th: Still very restless. He begins to speak, though indistinctly, and is evidently not aphasic. The paralysis of the left third has almost wholly disappeared, and the suspected paralysis of the other muscles of the face is not noticeable. The left arm and leg are fully as powerless as they were, but they are now limp. Superficial and deep reflexes increased on left side. Urine still has to be drawn off; specific gravity 1028, no albumen.—29th: The patient has been very restless; has suffered from much pain in the bladder, and the urine has become offensive and alkaline. The bladder has consequently been washed out. The temperature, which ever since admission has varied between 99° and 100·2°, began to rise on the morning of the 28th, and this morning early reached 103·4°; tongue dry.—31st: The restlessness and severe pain in the vesical region have continued; but the urine, which still has to be drawn off, has ceased to be offensive, and has become slightly acid, and contains no trace of albumen. The temperature rose to 104·9° last night, when he had a rigor of twenty minutes' duration. This afternoon it reached 105·2° without the occurrence of a rigor; tongue dry; no rigidity of limbs; speech as before.—Jan. 2nd, 1882: Still restless and in pain; complains also of pain in the right side of the head and down the left arm; is quite sensible, and occasionally cries out. The limbs are rigid again, and since yesterday there has been slight ptosis of the left eyelid, and protrusion of tongue to left. The condition of the facial muscles is doubtful; tongue dry and brown; much vomiting; obstinate constipation; pulse 116. The temperature on the 1st fell from 103·2° in the early morning to 98·2° at noon; it subsequently rose again, and during the later part of this day and the 2nd varied from 97·8° to 101·4°; a bedsore on left buttock.—3rd: Much quieter, and almost unconscious. Both pupils much dilated, especially left; pulse 132; respiration noisy, 48 in the minute. Tongue very dry; paralytic symptoms unchanged; temperature varying between 100·8° and 103·5°.—4th: When seen this morning he was fast sinking, and wholly unconscious. He died at noon. His temperature rapidly rose before death. At 11 it was 106·6°; at 11.30, 107·1°, and at the time of death, 109·2°; half an hour later it was 108·4°

Autopsy.—Vessels of pia mater injected, but no trace of meningitis, and nothing abnormal as regards the form of the general surface of the brain, or the subarachnoid fluid. The posterior cerebral, and some of the smaller arteries in the neighbourhood, were much thickened, yellowish, and opaque, apparently the seat of syphilitic disease. But the other and larger vessels were fairly healthy. There was slight comparative softening of the left temporo-sphenoidal lobe; and the pons, which was somewhat swollen, was soft and semi-fluctuating. On incising this part an irregular patch of broken-down brain substance occupied the greater part of its right half, being separated from the surface, and from the surrounding healthy substance, by a zone of congested and apparently inflamed tissue. The substance of the temporo-sphenoidal lobe appeared fairly healthy. The rest of the brain substance was normal. There was, perhaps, a slight excess of fluid in the ventricles. A few old pleural adhesions. Lungs congested and œdematous below. Larger bronchi full of muco-purulent fluid. Pericardium and heart healthy. The abdominal viscera presented nothing unusual. Kidneys rather large and pale. No syphilitic affection of any of these organs.

Softening of Right Crus Cerebri and Lenticular Nucleus; Left Hemiplegia; Paralysis of Right External and Left Internal Rectus, and later of Right Facial and Right Hypoglossal Nerves; Nystagmus; Giddiness; Headache; Emotional and Mental Disturbance.—H. T——, a labourer, aged forty-six, came under my care on Dec. 11th, 1879. He has been a temperate and healthy man, and has had no important illness since childhood. Never had syphilis. His illness began early in November with a sense of coldness and shivering, which were not relieved by sitting in front of the fire. The next day he first complained of giddiness, and a feeling as if he were drunk. This giddiness, which continued, was most marked in the morning, and was always relieved by lying down. He further complained of pain at the right side of the head and neck behind, and also across the back of both eyes. He has had no nausea or sickness. On Dec. 7th he began to see double, and on the day of admission he first noticed that his left arm was weak, and his leg dragged. He is a well-nourished man. He is quite sensible, and complains of constant headache, liable to exacerbations of a shooting character, and referred mainly to the back of the right ear and the occiput. He is very unsteady in his gait, and inclined to fall over, but not to one side more than to the other. Can stand with eyes shut when legs are kept apart, but not when feet touch. The movements of both legs are somewhat ataxic; patellar reflex slight. His left leg is somewhat weaker than the right, and the left hand grasps much more feebly than its fellow, and cannot be raised above his head. There is marked weakness of the muscles of the lower part of the face on the left side. The pupils are equal, and respond to light, and there is no very obvious squint. But he complains of seeing double, especially when he looks to the right. In trying to turn his eyes to the right, the right eye lags a little and oscillates. The movements of the left seem quite natural. Optic discs healthy. Tongue protruded straight. No loss of cutaneous sensibility or of control over rectum or bladder. No defect of speech. There are no signs of thoracic or abdominal disease; and the urine is free from albumen and healthy. During the next few days the patient rapidly got worse; he became restless and troublesome, and rambled; he grew emotional, but usually disposed to cry; he lost control over his bladder; his arm became much more enfeebled, and he could do little more than move the fingers; the paralysis of the left side of the face got confirmed, and his tongue was protruded to the left; he still com-

plained of headache, mainly in the right occipital region, and the movements of the eyes became more defective. They were carefully examined on the 16th by Mr. Nettleship, who reported as follows:—"There is diplopia when patient looks to right, but not to left. The movement of the right eye outwards is defective, and efforts to effect it always cause rapid horizontal nystagmus. The left eye cannot be moved inwards beyond the middle line, and the attempt to move it in this direction always causes vertical nystagmus, which is much slower than the nystagmus in the right eye. Both eyes can be freely moved upwards and downwards, but these movements are attended with vertical nystagmus. The only movement of the eyes unattended with nystagmus is that to the left. There is paralysis of the left internal rectus, and in a less degree of the right external rectus. There is no optic neuritis." He remained in much the same state for the next two or three weeks; emotional, rambling, and complaining of pain and sometimes tenderness at vertex; but the paralysis of the left internal rectus diminished somewhat, and on the whole the weakness of the left arm also diminished. The left pupil became larger than the right. On Jan. 6th, it was noticed for the first time that the right side of the face was smoother than the left; that the right eye did not close so perfectly as the other; that the tongue, which had hitherto inclined slightly to the left when put out, now protruded distinctly to the right; that he talked with difficulty, and that he had some difficulty in swallowing. From this time he gradually became more and more feeble-minded and more and more prostrate, without any material change or aggravation in the paralytic symptoms. On Jan. 31st, special note was made of the presence of difficulty of deglutition and of stertorous breathing. On the morning of Feb. 1st, his temperature for the first time exceeded the normal. At this time he became comatose with stertorous breathing, his respiration being 72 in the minute; his pulse was 160; his temperature 102·7°, and his skin was damp. In the course of the day his temperature rose to 103·2°, and he died at seven that evening.

Autopsy.—Dura mater and skull healthy; arachnoid and subarachnoid tissue somewhat opaque, with patches of fibroid thickening; slight atheroma of vessels at base. The only lesion discovered in the brain was a patch of softening, with yellow discolouration, which involved the right crus cerebri and the right lenticular nucleus. The surface of the crus looked healthy; and no marks of disease were apparent in the wall of the ventricles. The nerves at the base looked healthy. There was some congestion and lobular pneumonia at the base of the lungs. No other lesion was discovered.

Thrombosis of Basilar Artery; Softening of Anterior Part of Pons; Left Hemiplegia; Death from Bronchitis.—John B——, a labourer, aged thirty, was admitted, under Dr. Stone, on March 16th, 1882. He is said to have been a temperate man, and to have had no previous illness; previously, however, he must have suffered for some time with bronchitic symptoms. He was taken ill five days ago, while at work, with giddiness. He was not sick, and did not fall down; and, indeed, was able to walk home unassisted. After reaching his home he gradually lost power in the left arm and leg, and also his speech, which, however, has improved since. He is a fairly healthy-looking man, but hemiplegic on the left side. There is complete loss of power in the arm; the leg is only partially paralysed; the mouth is drawn to the right, and the tongue, when protruded, points to the left; pupils equal, contracted, no squint or impairment of vision; speech thick and indistinct; no aphasia; no loss of sensation, either of touch or of special senses. He is quite sensible. He has a frequent dry cough, and some difficulty in breathing. The respiration is 32 in the minute; the breath sounds are attended with sibilant and sonorous rhonchi; chest resonant; heart's sounds and action normal; pulse 100; urine pale, slightly acid, sp. gr. 1015; temperature 99·2°. The paralytic phenomena continued without change, but the bronchitis and dyspnœa increased rapidly; and he died of the effects of bronchitis on the evening of the 22nd. Before death he became very livid and partly unconscious; his respiration rose to 48 in the minute, and his pulse to 144. His temperature never exceeded 101°.

Autopsy.—The basilar artery, just before giving off the posterior cerebrals, was obstructed for a length of two or three lines by a firm decolourised adherent clot, and the fore part of the pons was softened, and broke up under a stream of water. No other cerebral disease whatever was discovered. The heart was enlarged on the right side; but all the valves were healthy; and there were no vegetations. The tricuspid, however, was incompetent under the water test. The pleuræ were extremely thick and strongly adherent. The lungs were congested, and the bronchial tubes were dilated, and contained muco-purulent fluid. Other organs healthy.

Lecture
ON THE
DIAGNOSTIC USES OF ELECTRICITY IN DISEASES OF THE NEURO-MOTOR APPARATUS.

Delivered at St. Mary's Hospital,

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GENTLEMEN,—We have studied on previous occasions the phenomena of motor and sensory nerve excitation by electric currents in the healthy man. We have seen that stimuli of the same nature and strength produce similar results under similar conditions. Among other facts we have seen that when an electrode is placed on a muscle, the easiest reaction to obtain was the kathodic closure contraction (K. C. C., the electrode being negative or kathode, and the circuit being closed or the current made), and that the anodic closure contraction (A. C. C., the electrode being positive or anode), appeared with a higher current strength. Healthy muscle does not so readily contract to the opening or break excitation (K. O. C., A. O. C.) as nerve, nor does it so readily remain in a persistent contraction during the passage of strong galvanic currents (duration tetanus, K. D. T. and A. D. T.) Let us now consider what happens in nerves and muscles which are the seat of some motor disturbance. The results of an electrical examination may establish one of three things:—(1) The nerves and muscles examined react *normally*. (2) Their reactions present *quantitative* abnormalities—that is to say, there is either an excess or a deficiency in the amplitude of the contraction following an excitation of given intensity. (3) They present *qualitative* abnormalities—that is to say, (*a*) the order of apparition on relative amplitude of the muscular contractions to the kathodic and anodic make and break of the galvanic current is altered ("serial" alteration); (*b*) the mode or course of the contraction or "myographic curve" is altered ("modal" alteration). When qualitative alterations are present, quantitative changes are invariably present also. This combination of quantitative, serial, and modal alterations in the muscular response is known as the "reaction of degeneration" (R. D.)

1. The only direct inference to be derived from the reactions of nerves and muscles to electricity relates to the state of their nutrition. If these reactions are abnormal, their nutrition also is abnormal. When speaking of the reaction of degeneration we shall have the opportunity of dwelling more fully upon this important topic. In the meanwhile we may content ourselves with bearing in mind, first, that the normal nutrition of nerves and muscles indicates a healthy condition of the nerve-centres in the anterior spinal cornua, and of the nerve-fibres themselves, from the ganglionic cells composing those centres, down to the motor end plates; secondly, that such a normal nutrition is consistent with very considerable disturbance in the functions, whether in the direction of excessive or of diminished motility of the organs examined, depending upon various lesions of the higher nerve-centres and paths.

The diseases of the neuro-muscular apparatus in which the reactions are found to be normal are chiefly—(1) Cerebral disease or injury affecting the corpus striatum, peduncles, &c.; in other words, all paralyses and spasms of cerebral origin, whether due to organic or functional disturbance (hysteria, epilepsy, chorea, &c.), are mostly unaccompanied by any alteration of the electrical reactions as long as no secondary changes are set up in the cord. (2) Spinal diseases affecting the white matter only frequently do not influence the electrical excitability, at least during their first stages:

such are locomotor ataxy, lateral sclerosis, disseminated sclerosis. (3) Spinal lesions affecting a circumscribed portion of the cord in its whole thickness give rise to no electro-diagnostic phenomena in the parts below the part affected (transverse myelitis, compression, crushing, &c.) The nerves and muscles under the direct influence of the diseased portion will present the reactions of degeneration. Certain morbid states of the peripheral nerves, such as in the mildest cases of facial or musculo-spiral paralysis from cold or pressure. We have already said the only direct conclusion to be drawn from the fact that the electro-excitability[1] is normal, is that the nerves and muscles which are the seat of the alleged diminution or excess of motility (paralysis or spasm, hypo- or hyper-kinesia), have not suffered in their nutrition. This conclusion is consistent with the coexistence of any one of the morbid conditions enumerated above, but does not exclude the possibility of shamming on the part of the individual examined. In order to determine the latter point we shall have to consider whether the history and other symptoms of the case tally with one of the diseases shown to be possible by the electrical investigation. If we are satisfied that the case is genuine, we are enabled by the discovery that the reactions are normal to exclude the participation of the spinal grey matter or of the nerve-trunks in the production of the symptoms. In some cases, no doubt, the clinical aspects of a case dispense altogether with the necessity of consulting the electrical reactions, or restrain its utility to the determination of any secondary changes which may have supervened in the cord or peripheral nerves. But in not a few cases the presence or absence of electro-diagnostic signs is of the highest significance, and give the only clue to a true interpretation of the symptoms. Thus, to give but an example, I shall mention the discrimination at an early stage of cerebral paralysis (cortical, hysterical) from true spinal (poliomyelitic) disease.

2. *Quantitative changes.*—If the excitability is (*a*) *augmented*, the nerves and muscles reacting to a lower minimal stimulus than normally, or to the contractions being excessive to a given current strength, we may indeed conclude to some actual change in the molecular state of the nerve, but the information gained is not of any great practical importance, as the nature of that change is entirely hidden from us. It is supposed to depend in many cases upon an irritation or exalted reflex activity of the anterior cornua of the cord. Hyperexcitability is found in the early stages of cerebral hæmorrhage, of locomotor ataxy, of facial paralysis, &c., but the phenomenon is not constant, especially in the hands of observers who eliminate the effects of altered body resistances by means of a galvanometric control. It is, however, extremely well exemplified in tetanilla, where the peripheral nerves have also their mechanical excitability exalted to a very remarkable degree. Increased excitability of muscles to the galvanic excitations is a characteristic feature of the early stages of degenerative reactions, as we shall presently see. (*b*) *Diminution* of the excitability (besides being a very constant accompaniment of the R. D. in several of its phases) occurs under numerous conditions, and may culminate in total abolition of response. Old-standing cerebral paralyses, especially when dating from youth, and still more diseases of the spinal white matter in their later stages, are characterised by a deficiency in the the neuro-muscular excitability. The same may be said of certain cases of very slowly progressing muscular atrophy, in pseudo-hypertrophy of the muscles, and perhaps in the milder forms of idiopathic neuritis. Simple muscular atrophy from disease, wasting diseases, or affections of the joints, is accompanied with deficient response to maximal rather than to minimal excitations. From this enumeration it is obvious that the chief conclusion to be drawn from the occurrence of diminished electrical reaction is more than a negative one. It excludes on the one hand poliomyelitis, on the other hysteria, and all purely cerebral disturbances, as well as shamming. It invariably points to certain alterations in the nerve fibres. In numerous cases it enables us therefore to prove the organic nature of a disease, and assists in localising and estimating the depth of the lesion. In such cases, where the other features of the disease are not well marked, and where at the same time the diminution of excitability is slight, the utmost care in applying the principles of investigation laid down previously must be taken before we can place any reliance upon the results; for, having here no qualitative changes to assist us in forming an opinion, we depend entirely upon an accurate dosage of our exciting agent in the diseased as compared to the standard healthy nerve.

We do not know exactly the nature and amount of organic changes in the peripheral organs to which diminution of excitability is to be attributed. Nor can any reliable prognostic conclusion be always founded upon the degree of that diminution. It is important, in connexion with this subject, to remember that a nerve which has regained its functional activity—after complete section, for instance—may remain for months or years without regaining its electro-excitability below the point of lesion, though perfectly able to transmit volitional or artificial impulses from above. We know that such a nerve has undergone a process of degeneration and of regeneration, but it is not yet perfectly clear why the latter stops short of restoring to the nerve its electro-excitability. It is scarcely permissible to conjecture as yet that the changes in peripheral nerves following old central (cerebral or leucomyelitic) lesions are of the same nature as this post-regenerative alteration. Still, such a possibility suggests itself almost involuntarily to the mind. The fact, however, remains incontrovertible that diminution of excitability is due to some alteration, of local or central origin, in the normal constitution of the nerve.

3. The reactions of nerves and muscles present quantitative and qualitative (serial and modal) abnormities; *reaction of degeneration* (R. D.) The phenomena attending excitation of the nerves and excitation of the muscles follow widely different courses, so that it is necessary to consider them separately. (*A*) Alterations in the reactions of nerves. These consist mainly in a more or less rapid diminution of excitability (to both currents equally) according as the progress of the morbid changes is quick or slow. When the functions of the anterior horns of the cord are suddenly suspended, as in infantile paralysis, or when a peripheral nerve is divided accidentally, or becomes the seat of a circumscribed acute process, as in ordinary facial paralysis, the nerve becomes unexcitable below the point of the lesion within two weeks. When the original disease is developed more gradually, as in chronic polio-myelitis or neuritis, the loss of nerve-excitability proceeds synchronously, and may continue to progress for many weeks or months. The nerve reactions rarely show any qualitative changes; in certain cases, however, it is found that the muscular contractions obtained indirectly by galvanising or faradising the nerve are modally affected—that is, lose their character of an instantaneous twitch, and become sluggish as well as feebler. Serial modifications in nerve response have also been observed, but for the present time must be looked upon as exceptional occurrences. The period during which a nerve remains unexcitable varies considerably. In cases where, owing to the depth of the lesion, recovery does not occur, excitability never returns; but in certain cases, as we have already stated, it remains in abeyance for a long time after the nerve has been restored to its physiological integrity as an organ of transmission. Usually, however, the return of electro-nervous excitability follows closely upon the first manifestations of that integrity—i. e., upon the first transmissions of voluntary impulses. (*B*) *Alterations in the reactions of muscles.* (1) *Quantitative.*—On exciting a muscle directly with (*a*) *faradaism*, after the section of its nerve, or disease in or below the anterior spinal cornua, the phenomena are found to follow a course absolutely similar to the one they take in the nerve itself. This fact is fully concordant with the theory that by direct faradaic stimulation of the healthy muscle it is really the intra-muscular nerve elements, and not the muscular fibres themselves, which are excited. Muscular substance requires stimuli of longer duration than the instantaneous fluxes of induction for its excitation. The disappearance of farado-muscular excitability is synchronous with the degeneration of the intra-muscular nerve elements. The effects of (*b*) *galvanic* excitation of muscle are highly characteristic. First, quantitative changes are present. Where the morbid process is acute there occurs first a slight diminution of response, soon followed by a well-marked rise. This rise is particularly well seen in severe facial paralysis of "rheumatic" origin, and in traumatic peripheral paralyses. In such a case the rise begins during the second week of the disease,

[1] The term *electro*-excitability should be carefully restricted to its generic sense, including within it both *galvano*- and *farado*-excitability, or contractility. I do not in the least intend to convey, by these several expressions, that there is a special property in nerve and muscle by which they react to electrical stimuli, but use the terms in order to avoid the fastidious repetition of a longer, though more correct, periphrase.

and rapidly reaches a point where the weakest galvanic current (two or three cells, as against eight or nine required to produce contraction on the healthy side) is enough to excite the muscles. This galvanic hyperexcitability persists for several weeks, gradually sinking back to normal, or below normal, according to the depth of the nutritive changes in the muscle. In chronic cases the diminution is the only quantitative alteration observed in the muscular response. (2) *Qualitative* changes characterise the muscular contractions at the same time. They are both *modal*, the contraction being of a different kind than in health, sluggish, long ascent and descent, maximum shortening diminished, and *serial*. The diagnostic value of (*a*) the *modal* changes is not often found adequately recognised (when it is not completely overlooked) in electro-therapeutical writings; and yet it is quite equal to that of the other modications of muscular response to galvanism. In many cases a protracted contraction wave is the only ground upon which we can base our judgment as to whether R.D. is present or not.[2] This sluggish course of the muscular wave insensibly passes into the tonic contraction to be mentioned presently, the muscle remaining contracted during the whole time the current is flowing through it. (*b*) Serial changes consist chiefly in the overtaking of K.C.C. by the A.C.C. Instead, as in normal muscle, of requiring, say, fifteen cells to obtain A.C.C. where eight or ten give the first K.C.C., you require only twelve, ten, or fewer cells. A similar inversion is sometimes noticed between A.O.C. and K.O.C., the latter being more easily obtained than the former, but the opening contractions usually become fainter, and disappear altogether within a short period after the disease has set in. K.D.T. and A.D.T., on the other hand, become very marked, the latter especially, the muscle remaining in a state of persistent shortening during the whole duration of currents just strong enough to produce a closure contraction. The length of time during which the qualitative alterations of muscular response may be observed varies with the general course of the disease. If recovery never takes place, the galvano-muscular excitability goes on sinking for a year or more; traces of A.C.C. to strong currents may be elicited for a very long period in the last remainder of the dying muscular tissue. Just as voluntary stimuli find their way through nerve-fibres still unexcitable to faradisation, so muscle may go on showing phenomena of R.D. when fit to obey the command of the will. R.D. may likewise be demonstrated in muscles which never have yet shown any signs of impaired functions, such as, for instance, in lead-poisoning, the extensors of the hand before any sign of wrist-drop is noticeable. Indeed, it cannot too explicitly be stated that paralysis and R.D. are symptoms between which there is no essential relation. What does R.D., then, mean? What are the pathological conditions to which it corresponds, and the alterations of nervous and muscular tissue to which it is due? It is of importance that we should have perfectly clear ideas on this point. The occurrence of R.D. depends upon a specific histological modification of the irritable tissues called "degenerative atrophy" (not idiopathic myositis, not simple atrophy or "wasting"), and this degeneration itself is due to an interference with, or a stoppage of, the peculiar influence of the grey matter (bulbar nuclei, anterior horns of the cord) upon the nerves and muscles, known as the "trophic" influence. Hence, from the occurrence of R.D., whether complete or partial, we conclude to an alteration either of those centres themselves, or of the channels which convey their influence. These channels are the motor fibres, as proved by the results of experimental pathology. According to the latest researches section of a motor nerve is rapidly followed by coagulation of the medullary sheath, softening of the axis cylinder, and the breaking up of both, which eventually become reduced to a homogeneous mass of protoplasmic material filling the sheath of Schwann. The axis-cylinder does not survive, as was formerly believed, except when the nerve injury has been very slight. The neurileumma does not remain passive, but proliferates, and a cirrhotic condition of the nerve ensues. The intimate processes connected with the regeneration of nerve fibres have not yet been elucidated. Whilst the sectional nerve is going through these phases the muscles it innervates is the seat of corresponding histological changes. The fibrillæ lose their distinct striation, and apparently undergo an alteration in their chemical composition. There is proliferation of nuclei, and of the connective tissue, leading also to a cirrhotic condition of the muscle. The regenerative process begins when the nerve has been restored sufficiently to exert its influence upon the muscular fibre.

(To be concluded.)

[2] The exaggerated mechanical excitability of muscular tissue presenting the phenomena of R.D. has been noted by Erb and Hitzig. This property probably depends upon the same histological changes which give rise to R.D.

A NOTE ON THE PRACTICE OF SURGERY.

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THE observation that doctors are too prone to act upon insufficient evidence is a very old and familiar one, and from time immemorial it has been the occasion of much wit and satire. The attempts which so often have been, and still are, made to establish some principle of treatment or mode of practice on inadequate grounds is, of course, to some extent natural and perhaps inevitable. The enthusiasm of inquiry, the force of impressive facts recently witnessed, go far to explain it; but withal, when carried, as perhaps it too frequently is, to an extreme point, it is apt to produce much mischief, to say nothing of discredit. Single cases, for instance, are not unfrequently quoted in this way, as if they could prove or show that the result which they illustrate is the usual or probable one. A consultation is held on the treatment of some obscure case; an important measure, such as an operation of very doubtful prospect, is proposed; an objection is taken to it on the score that it will probably fail or prove fatal; then immediately some one tells of some single case in which he was concerned when it turned out to be successful. Now if such a single instance be only used to show that the operation in question is practicable, that it may be successful, that it is possible for it to answer the desired end, well and good; or if it be used in illustration of the argument, no reasonable objection can be raised against it. But what further use ought to be made of it? If it be the sole instance in which such an operation has been performed, then of course it stands alone, and must be taken for what it is worth. But if it be only one case out of many, or even of a few similar ones, it is clear that its value in the question can be adequately measured only when it is taken in conjunction with the rest. A. and B. are considering the question of an operation on C. A. urges it because he has had one or two or three successful cases of the kind. But supposing A. or B. knows of twice or thrice as many others which have proved fatal or otherwise disastrous, how then does the evidence in reference to the operation before them stand? Surely we sin too often against reason in this way. Who cannot recall too many instances? It is, of course, clear that mistakes from this cause may arise in either direction, in the way of action or inaction; but who that has had much experience can doubt in which direction the greatest danger lies?

Closely connected with this carelessness of thought is a certain looseness of expression with regard to the result of particular operations. When an operation is said to be successful, what is to be understood? Surely it should mean that the end for which the operation has been performed has been accomplished. There must be a purpose in every operation, and unless it has been reached the operation must have failed. But how often is the term "success" applied to recovery only from the injury inflicted by the operation itself without reference to the object for which it was undertaken or knowledge of the result. If an operation be performed solely for the purpose of saving life which, but for such timely help, would have been forthwith sacrificed, then, indeed, recovery from the operation itself is fairly entitled to be called success; but if an operation be performed for the repair of some defect or the correction of some deformity, or with the object of removing some hindrance to the action of a part or of increasing its usefulness, then, although the person may recover rapidly from the operation itself, unless such end be gained it must be pronounced a failure; nay, even if an evil be removed, and another equally grave be established in its place, the term "successful" cannot fairly be applied to the operation. In some cases many weeks or months must necessarily elapse before it can be seen whether the purpose of the operation has been attained, and yet how many cases have been recorded as successful long before the period has arrived at which the question could be fairly

answered. For example, an operation is performed for the removal of some hindrance to the strength or activity of a limb. As soon as the patient has recovered from the operation the case is published, or at all events from that date no further information is given or perhaps obtained of the result; yet clearly the chief fact which requires to be ascertained is the condition of the limb at a remote period. If the operation be really successful, by the omission of such knowledge an injustice is done to it. If it be not successful, then by such silence an injustice is done to surgery.

Again, I cannot help thinking that the practice is, in some instances, too common of throwing the responsibility of an operation upon the patient. Surgeons perhaps are sometimes too prone, as the result of deliberation, to declare, Well, I will put the matter before the patient and leave him to decide. Now it strikes me that this can hardly ever be quite right. As Sir James Paget has said, "As to the amount of good which is to follow an operation the surgeon alone can in most cases estimate it. In most cases therefore we must take the whole responsibility of operation, for it is only on our statements that patients can rely in judging whether they should submit or not; and most of them, even when they have our statements before them, are quite incapable of clearly and soundly judging." And not only so, but too often it is in proportion to the degree of doubt in the surgeon's own mind that he becomes anxious to shift the responsibility. When the case is clear to him he expresses a positive opinion, but when the advantages and objections are more equally balanced he attempts to place them before the patient and to leave the issue to him. It is therefore in cases in which decision is most difficult that the patient is called on to decide. This ought not to be. Sir James Paget would make an exception in cases of what he wittily calls "decorative surgery." But I confess it seems to me that even this exception should be admitted only with considerable qualification. For when a man or woman is promised a better appearance as the result of an operation, how can either judge of its degree? When, for example, a surgeon proposes to make a new nose, can the patient picture at all adequately the new feature? And yet this is a point of the highest importance in coming to a decision between a new organ of flesh and an artificial one. I think that whenever the surgeon places the whole case fully and fairly before the patient he should at least never withhold his own opinion; and the instances ought surely to be very exceptional indeed in which he should act in opposition to it.

STEWED FRUIT FOR THE GOUTY AND THE DYSPEPTIC.

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PROBALY the impression first created by scanning the title of this paper will be as follows:—"Why, what have either the gouty or the dyspeptic to do with stewed fruit at all?" That sugar is apt to disagree with sundry stomachs, causing great acidity, is a clinical fact not to be disputed. But because such is the case with a limited number of persons it does not seem, to me at least, that therefore a sweeping prohibitory law is to be laid down for a large section of the community. Gout poison, all admit, is a product derived from the albuminous constituents of our food, as nitrogen is a marked element in its composition. It is, then, the albuminous element in our food which has to be avoided in lithiasis. How sugar, fruits, and even vegetables came to be banned my researches have not enabled me to ascertain. From the time of Magendie's path-breaking essay writers on gout have advised the restriction of the nitrogenised, or azotised, constituents of our food in cases of lithiasis. But that the objection to sugar in gouty cases exists may not be denied. In speaking of stewed fruit for the gouty and the dyspeptic my views will be heterodox in the eyes of many. But neither the light of chemistry nor the lessons of practice conflict with my views. I am quite prepared to undergo any criticism these views may elicit or provoke. Indeed, the subject would be all the better for being thoroughly ventilated.

At the outset, I admit that for many persons—gouty, dyspeptic, and glycosuric—ordinary stewed fruit is objectionable from the amount of added sugar it contains. Where the acidity of fruit is masked or hidden by an excess of sugar, then the resultant product is cloying to many palates, and offensive to many stomachs. Probably in this all readers will agree with me. But it is by no means necessary to render stewed fruit objectionable by adding much sugar to it. Deprived of this excess of added sugar, stewed fruit can not only be rendered unobjectionable, but be converted into an actual prophylactic measure, especially in cases of lithiasis. In order to attain this end all that need be done is to neutralise the excessive acidity by an alkali, and then little or no sugar is required. Thrifty housewives have long been familiar with the fact that the addition of a small quantity of the bicarbonate of soda to stewed fruit reduced the acidity, so as to save the necessity for much sugar. This was done simply for economy. The principle has a far wider application. Last June I was requested to visit a lunatic in the Midlands who was also gouty; and when the gout was acutely present she was more excitable and violent than usual. No medicine would she take, but she was very fond of stewed fruit. To add potash to her stewed fruit was very easy, yet very effectual. After this I gave my cook instructions to perform a series of experiments for me with all our ordinary native fruits. The result of this was that the amount of bicarbonate of potash required for each pound of fruit was found to be about as much as would lie upon a shilling. And this is a much better guide for a cook than to put so many grains. With all fairly ripe fruit this was just sufficient to neutralise the acidity, and bring out the natural sweetness; indeed the resultant product was quite sweet enough for most adult palates. Such stewed fruit could be eaten alone, or with milk puddings, or with cream, or the Swiss milk in bottles. Gooseberries, currants of all kinds, apples, and plums, all alike were excellent when so prepared. There are some points, however, to be attended to in practice, which are of more or less importance. The first matter is this: with dark fruits, as the black plum, for instance, the colour is impaired by the alkali, and the fruit is less attractive to the eye than is that of the ordinary stewed fruit, which is of a deep clear crimson. This matter is easily got over: a little cochineal will give the desired colour. Another is this: where there is no natural sweetness to neutralise the acid completely by an alkali leaves nothing, simply a cold mass, to which the palate is absolutely indifferent. Such is the case with rhubarb. Here it is well to use half or all the amount of alkali with some sugar. The same is the case with early gooseberries before they have any natural sweetness; no sugar formed in them. Here the full quantity of alkali should be used, and the remaining acidity met by sugar. Where three-quarters of a pound of sugar is required to sweeten one pound of fruit, only one-quarter of a pound of sugar is necessary after the alkali has been added. The sour-sweet taste is thus secured, which is toothsome. Now, in these two instances the stewed fruit is only rendered less objectionable to the stomach plagued with acidity, not made quite inoffensive. But for ordinary gouty individuals not troubled with acidity of the stomach, such stewed fruit is quite admissible, and forms a pleasant method of taking potash. The whole subject is one which deserves attention from invalids as well as their medical attendants, as it opens up to many a new field of diet altogether. Fruits *au naturel*—as the strawberry, for instance—are good in gout from the salts they contain, and are unobjectionable stewed, if it were not for the acetous fermentation of the added sugar. Here soda may be used. But where there is lithiasis the alkali ought to be potash. The gouty and the bilious alike are troubled with the products of the metamorphosis of albuminoids. Neither the lithates of the gouty nor the bile acids of the bilious are derived from the saccharine or farinaceous elements of the food. It was possible to make bricks without straw, but it is impossible to make bricks without clay! No liver can make these nitrogenised substances from simple hydrocarbons: it is physically impossible! The dietary for each is the same—a non-nitrogenised dietary, in which vegetables and farinaceous matters are indicated, and saccharine matters, too, unless acidity in the stomach is produced by them. Milk puddings and stewed fruit are excellent for the dyspeptic, the bilious, and the gouty, as my experience tells me; and for one of those who suffers from taking sugar nineteen would be all the better for stewed

fruit. But for those who dislike sweets, and for those who suffer from acidity, it is well to prepare the stewed fruit with alkalies, completely and solely or partially; as the case may be. This may sound very heterodox to some readers; but just let the incredulous test the matter for themselves.

Now, there are two other matters remaining to be alluded to, on which it is impossible to speak dogmatically or *ex cathedrâ*; they are, rather, matters of personal belief, and they are these:—1. It does not seem a matter of indifference in lithiasis what forms of albuminoids are taken. The flesh of animals is rather converted into peptones by pepsin in an acid medium—that is, by gastric digestion—than by trypsin in an alkaline medium. And such peptones seem specially liable to form lithates. Caseine is more specially digested by trypsin in the intestine, and such caseine peptones seem less readily converted into lithates; the clinical fact being that a milk dietary or a pulse dietary is good for the subjects of lithiasis. Caseine is the form of albuminoid it seems to me, best suited to the gouty. Milk or milk puddings (made without eggs) are capital food for the cholæmic or the lithæmic. These fibrin-albuminoids, digested by pepsin, are laxative, while caseine is binding or constipating.

Milk puddings, then, go well with stewed fruit, which is a laxative. Many thoughtful physicians agree with me in the above matter. Now I am approaching what some may hold very disputable ground, yet nevertheless I venture to say here what I am beginning to think. Both for the classical diabetic and the glycosuric, cane sugar—the sugar of commerce—is bad, producing the unpleasant symptoms of sugar in the blood very readily. Yet many glycosuric individuals can take farinaceous matter with comparative immunity from discomfort. Starch in its way to grape-sugar is much less troublesome than is cane-sugar passing into grape-sugar, why I do not know, but the fact remains. Now, with many glycosuric individuals fruit stewed in the manner advocated here is quite permissible, while ordinary stewed fruit is very objectionable. For the dyspeptic, the gouty, the bilious, and the glycosuric individual (as well as the truly rheumatic, a small class), fruit stewed with an alkali in the proportion of as much bicarbonate of soda as will lie upon a shilling to the pound of fruit, when put in the oven, will be found both palatable and permissible. It saves the gastric acidity from the acetous fermentation of the sugar in the dyspeptic, or with the glycosuric relieves him from the excess of cane-sugar which disagrees with him. Where there is distinct gout not only is fruit stewed with an alkali good and unobjectionable; but if it be prepared with the bicarbonate of potash, it is converted into a therapeutic agent of no mean value; while the resultant product is quite sweet enough for a palate which has outlived the "sweet-tooth" period. The whole matter is a simple one, yet it seems to contain much promise for many persons.

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ON RUPTURE OF THE BLADDER.

WITH NOTES OF TWO CASES.

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IN the very able articles by Mr. Rivington on "Rupture of the Urinary Bladder," published in THE LANCET during last year, the author stated at the outset[1] that one of his objects was "to examine critically the cases which have been adduced as instances of recovery after rupture into the peritoneal cavity." In a later number[2] he discredits the diagnosis in seven out of the eight recorded cases of recovery which he had collected, and amongst them is one reported by me.

Though Mr. Rivington has included my case in the *intra*-peritoneal group, with the result of turning it out again, I wrote of it: "There is no doubt the wound was in the front wall of the bladder, chiefly, *though perhaps not entirely, extra*-peritoneal, and being high up in the organ, comparatively little urine escaped through the rent, while the bladder preserved some of its power of retaining and expelling its contents." Mr. Rivington takes exception to the diagnosis on the ground that "the evidence of distension of the bladder is defective, as the man had passed water about an hour before the injury. According to the patient himself, he passed by his own efforts three-quarters of a pint of urine in the first thirty-six hours, and very likely the quantity was greater. ..... Plenty of urine was drawn off daily through an elastic catheter fixed in the bladder." The uncertainty as to whether the peritoneum is torn in any given case of ruptured bladder is so great that it may be plausibly questioned until actually seen, and Mr. Rivington may perhaps be right in his conclusion that the peritoneum in my case was not ruptured; but his summary of the evidence is a little misleading. My description was: "The patient stated that prior to the injury he had not passed water for 'an hour or two' (to use his own words), and that he had been drinking up to the moment of wrestling. He also said that during the thirty-six hours between the accident and his admission into the hospital he had 'certainly not passed more than three-quarters of a pint of blood and urine together' (again using his own words); that he had made several efforts before he voided anything at all, that which first passed being like pure blood, but that which was passed at subsequent attempts became more and more like natural urine." Mr. Rivington has himself shown that some forms of rupture of the bladder, without fracture of the pelvis, may occur when the organ is empty or almost so. His fourth case is an illustration thereof. But there is sufficient evidence, I think, that in my patient the bladder must have been distended above the level of the pubes, and that urine must have escaped from it at some spot; whilst it supplies just the set of conditions which all consider to be peculiarly predisposing to rupture of the bladder should injury occur to the abdomen, especially if the violence be applied, as it was to my patient, by someone kneeling upon the belly.

Quite apart from its particular reference to my case, the argument that the bladder is not ruptured because thirty-six hours after the injury the patient passes urine by his own efforts, and that subsequently plenty of urine can be daily drawn off, cannot be seriously maintained. Many cases disprove it, but none better than Mr. Rivington's own. Thus, in Case 1, some hours after the injury the medical attendant passed a catheter, and drew off a large quantity of blood. Death followed on the fourth day. There was a rent in the upper and posterior part of the bladder, and the recto-vesical pouch was filled with a blood-stained fluid. In Case 2, three hours after the injury five ounces of urine highly coloured with blood were drawn off; within thirty or thirty-six hours afterwards, sixteen ounces were drawn away, and on the third day ten ounces were drawn off, and six were passed by the patient; on the fifth day he again passed water by himself, "and probably more with a fluid motion." He died on the sixth day. "The rent in the bladder was in the upper and posterior part, and was vertical in direction.....Its lips were glued together by lymph, and it was undergoing repair. The bladder was not completely contracted. ..... There was a considerable quantity of flaky, turbid, urinous fluid in the pelvis." In Case 3 the house-surgeon drew off eight ounces of blood and urine, and during the four days the patient lived six or eight ounces of sanguineous urine were drawn off night and morning. At the post-mortem "a hole was discovered on the right side at the antero-lateral aspect of the neck of the bladder." In Case 4 there was incontinence of urine after the accident; bloody urine dribbled away, and on the introduction of the catheter more was drawn off, "the urine being expelled with some force. ..... No pain attended either the act of micturition or the passage of the catheter." The bladder was rent just above the prostate gland. In THE LANCET[3] there is a record of another fatal case in which it is stated that shortly after the accident a catheter was introduced into the bladder, and urine and clotted blood were drawn off. There was a rupture to the right of the vesicula seminalis, and "a quart of urine and blood-clot were found on the right side of the pelvic cavity."

Other cases showing the same facts might be quoted, but enough has been said to justify this very important induction—that neither the presence of urine within the bladder, nor its withdrawal by catheter, nor even its discharge by the patient himself shortly after the accident, negatives rupture of the urinary bladder; and, further, that urine may be daily withdrawn through a catheter or voluntarily voided by the patient after either intra-

[1] THE LANCET, June 3rd. [2] Ibid., Nov. 4th. [3] March 18th, 1882, p. 442.

or extra-peritoneal rupture of the bladder. Nor is there any difficulty in understanding how this can be. There is, however, much reason to fear that these symptoms have led surgeons too readily to conclude that a severe contusion, but not a rupture of the bladder, has occurred; and thus no precautions have been taken to prevent urine from first accumulating in the torn bladder, and of then escaping through the rent into the parts beyond. The records of many cases suggest the inference that had steps been taken to drain or to frequently remove the urine from the ruptured bladder, the initial extravasation would not have been increased, and repair might have been completed.

Mr. Rivington, in the last of his instructive articles,[4] uses an argument which he would not apply, I think, to other departments of surgery. He says, "Apart from the objections which can be urged against the genuineness of the recorded recoveries after intra-peritoneal rupture of the bladder, there is one circumstance which would quite justify us in setting the cases on one side in considering the question of treatment; and that circumstance is the remarkable fact that if the genuineness of all the eight cases were to be admitted, the effect in regard to the selection of the best method of treatment would be thoroughly bewildering." But ought the genuineness of the cure of any number of cases of popliteal aneurism, for example, to be called in question, or the cases themselves to be set aside in considering the treatment of the disease, because some of them were cured by flexion, some by Reid's method, one by manipulation, others by compression in one or other of its various forms, others again by one of the many kinds of ligature? If the objection of manifold methods of treatment is not to be applied to aneurism, then why to ruptured bladder? Mr. Rivington thinks that the inference would be that one mode of treatment is as good as another, and this "lame and impotent conclusion" would "mar the prospect of attaining an effectual means of dealing with a most fatal lesion." But what if there are several effectual methods, not all suitable for every case? Are we to condemn them because they differ in their details from one another?

Mr. Rivington next states a proposition which, if properly interpreted, must meet with pretty general acceptance—viz., "that in neither form of rupture, the intra-peritoneal or the extra-peritoneal, can reliance be placed on constitutional and general means of treatment. ..... If any hope is to be entertained, it lies in the prompt application of efficient local treatment." It may be remarked in passing that each of the cases of recovery which he criticises was treated by one or other of the six methods of local treatment which he discusses.

The plan of treatment which I believe will be found most generally successful is to take care that the urine is removed as it enters or soon after entering the bladder, so as to prevent a further and a continual extravasation, and to guard against the reopening of the wound which will undo repair and excite fresh hæmorrhage and inflammation. This may be done by frequent catheterism, or by retaining a catheter in the bladder; or by encouraging the patient to pass water at short intervals if the power of doing so is still preserved to him. Nature may furnish the equivalent of constant catheterism, and in frequent micturition we may obtain a good substitute for the catheter. If neither the catheter can be borne nor the urine voided, median urethrotomy and the introduction of a drainage-tube through the wound ought to be resorted to. This line of treatment is, I believe, more important, more hopeful, and less hazardous than abdominal section, or than tapping the recto-vesical cul-de-sac, paracentesis abdominis, or random incisions into the pelvis or abdomen, with the view of evacuating with all possible speed the urine already effused; such measures will, I fear, but rarely be efficacious, though when the circumstances of the case seem to point to them they ought certainly to be tried.

The following two cases illustrate, and have suggested, some of the above remarks. The first case would have sufficed to convince us, had we not already been convinced, of the extreme difficulty of predicating the exact seat of a tear in the bladder walls. Though the fractured pelvis suggested an extra-peritoneal rent, yet the absence of any swelling to be felt per rectum at the time of admission, together with the completely empty state of the bladder, and the fact that nearly six hours had elapsed since the boy had passed water; also, the frequency with which fractured pelvis and a rent in a part of the bladder distant from the fractured bone are produced by the same accident, and the absence for several hours of any sign of urinary extravasation in the perineum or abdominal wall, led us to explore the abdominal cavity. The impression which this proceeding forced upon me, and one which I was fully prepared for from operations I have performed for removal of the entire uterus by the abdominal and abdomino-vaginal methods, was that to introduce sutures so as to bring the edges of a rent low down in the bladder accurately together it would be needful to employ some such needles in handles as are used for cleft palate or vesico-vaginal fistula.

CASE 1. *Rupture of the Bladder; Abdominal Section; Death.*—On Sept. 28th, 1881, at 11.30 A.M., a boy aged fifteen years was admitted into one of Mr. Hulke's beds in Broderip ward, having been run over by a nearly empty waggon. He had passed water on rising that morning, and had drunk a cup of tea at his breakfast at 6 A.M.; at 10.30 A.M. the accident happened. When admitted he was collapsed, pale, and cold; and it was stated that the wheel had passed obliquely over the pelvis from the right side. A catheter was passed into the bladder, but only a few drops of blood were withdrawn. At 1.45 P.M. I was asked to see him, in the temporary absence of Mr. Lyell, who was in charge of the beds. The boy was then still collapsed, white, and cold; no urine had been passed since 6 A.M.; there was a soft, diffluent, dark swelling in the right iliac region (evidently blood extravasated into the abdominal wall); there were several bruises over the right hip and buttock, and a linear graze two inches long by three inches and a half broad on the scrotum. There was neither swelling in the perineum nor around the rectum, nor tenderness along the urethra; but with the finger in the rectum I could feel the sharp point of the broken pubic arch of the right side projecting against the bowel; and also a wide gap in the pubic ramus of the left side. On withdrawing the finger it was seen to be blood-stained. The bladder was still empty, nothing but a few drops of blood coming through a catheter introduced into it. I could feel no rent in the parietes of the bladder by moving the point of the catheter over its surface. He was lying inclined to his left side with his thighs and legs flexed and a pillow under his right knee. Any movement of the thighs caused excruciating pain; so did pressure on the lower part of the abdomen, especially on the right side. Pressure could be well borne above the level of the umbilicus. Opium, warmth, and perfect immobility were ordered. The propriety of an exploratory abdominal incision was discussed, but further treatment was deferred until Mr. Lyell's arrival.

At 7.15 P.M. it was noted that the swelling in the right iliac region, though increased, was less striking owing to diffused swelling lower down, and in the right side of the perineum. With the finger in the rectum a soft yielding fulness was now felt around the anus; the fractured bone no longer projected against the rectal wall, but the whole symphysis gave the idea of being lower than natural and tilted on its transverse axis. Mr. Lyell made an incision along the linea alba for two inches, subsequently enlarging the wound until it extended from the pubes nearly to the umbilicus. The bladder was quite contracted, and could be only partially brought into view; its surface was easily explored with a catheter in the bladder and the finger in the peritoneal cavity, but no rent could be detected. A small quantity of blood-stained fluid, but no urine, was found in the abdomen. There was a little blood in the abdominal wall along the line of incision. A sharp edge of the broken pelvis was felt pressing against the peritoneum near the right side of the bladder. The abdominal wound was united by interrupted sutures, and a catheter was left just within the bladder. Death occurred at 2 A.M.

The necropsy was made by Dr. Fowler thirteen hours afterwards. The following is an abstract of his report:—Behind the peritoneum overlying the spine, as well as outside the peritoneum in the right iliac fossa, there was a large quantity of effused blood. Hæmorrhage had also taken place into the mesentery. The muscles and fascia of the iliac fossæ, pelvis, and prevertebral regions were found everywhere infiltrated with blood and blood-stained fluid. The peritoneum was separated from the anterior abdominal wall just to the right of the symphysis pubis, and was much bruised (by the broken pelvis), but not torn anywhere. The scrotum and perineum were very œdematous, and distended with blood and urine. In the front wall of the bladder, to the right of the median line and beneath the peritoneum, was a rounded tear about the size

[4] THE LANCET, Nov. 11th, 1882.

of a shilling, which extended through the coats of the bladder. There was no other sign of injury to the bladder. The urethra was not injured. The pelvis was very extensively fractured; on the right side each of the rami of the pubis was fractured about an inch from the symphysis, and through another fracture the head of the right femur was exposed. The left side of the pubic arch was fractured in three places, and a large fragment of its middle part was lying detached from the rest.

(To be concluded.)

CYSTOTOMY IN SUBACUTE CYSTITIS.

BY GEORGE ELDER, M.D.,
SURGEON TO THE HOSPITAL FOR WOMEN, NOTTINGHAM.

THE chronicity and intractability to the usual methods of treatment of catarrhal cystitis, especially in the aged, is my excuse for placing on record the undermentioned case, illustrating, as it does, the strikingly successful result obtained by cystotomy and subsequent drainage when all other means, local and general, had been long and fairly tried. The patient was a woman aged seventy-two years, with a rheumatic history, who was admitted under me at the Women's Hospital on Dec. 12th, 1882. For months previously she had been under medical attendance at home, suffering similarly to what she complained of on admission. There was incontinence of urine, accompanied with frequent desire to micturate, vesical tenesmus, dysuria, and constant burning hypogastric and vulvar pain. The calls to urinate were so frequent that it was impossible to obtain a night's rest. The vulva and contiguous skin were excoriated, and the seat of intense pruritus. There was considerable constitutional disturbance and declension in health. The urine was rather scanty; specific gravity 1018; offensively ammoniacal, and depositing abundantly pus and ropy mucus. Microscopic examination in addition showed the presence of pavement and cylindrical epithelium, a few fibrinous casts and phosphates.

Between December 12th and February 23rd all the ordinary medication, local and general, was tried, embracing rest in bed, hip baths, plain and medicated vesical injections, emptying the bladder at short intervals, alkalies, acids with and without sedatives, with the effect of relieving her distressed condition, but productive of no permanent improvement in the condition of the urine. Her general health also did not mend; so under ether a vesico-vaginal fistula was produced on the latter-mentioned date, and a winged catheter attached to a long piece of rubber tubing inserted. The rest given to the inflamed viscus by drainage combined with injections, first of a solution of hyposulphite of soda, and afterwards dilute nitric acid combined with quinine internally, and acidulated drink *ad lib.*, soon effected a change for the better in her local condition. Speedy relief was given to the tenesmus, weight and local pains, and on April 28th it was noted that for three days the drainage-tube had not been in place, and the urine which could be retained from two to three hours was passed per urethram without discomfort. No urine came through the fistulous opening, and it was clear, faintly acid, and depositing only a slight cloud of mucus. On May 9th she left the hospital entirely cured of her bladder troubles, passing painlessly perfectly healthy urine. The fistulous opening required no application beyond nitrate of silver. On May 31st the patient came to see me, and reported herself as able to retain her urine between three and four hours. The urine is normal and the fistulous opening closed.

Nottingham.

THE NIGHTINGALE FUND.—From the report for 1882 of this fund it appears that thirty-six probationer nurses were admitted to the school at St. Thomas's Hospital during the year and that thirty-two completed their year's training and received appointments. From the opening of the school in June, 1860, to the end of 1882, a total of 686 candidates have been admitted, and 414 have been entered on the Register as certified nurses. The receipts during the year amounted to £3390 and the expenditure to £1840, leaving a balance of £1550. The annual gratuity of £2 allowed by the regulations for the term of three years to certified nurses who have completed satisfactorily a year's service in some approved hospital was awarded to fifty-seven nurses.

ACUTE RHEUMATISM AS A PREMONITORY SYMPTOM OF PHTHISIS.

BY JOHN ALFRED AUSTIN, M.D.

RHEUMATIC FEVER has never been, as far as I am aware, put forward by any writer or observer as a premonitory symptom of phthisis. I have not even seen it mentioned, that an attack simulating acute rheumatism, and preceding the pulmonary symptoms, is occasionally observed as a phenomenon in the clinical history of that disease. Within the last few years, however, I have had under my observation no less than four cases of phthisis, in which the more decided pulmonary symptoms had been immediately preceded by the ordinary symptoms of acute rheumatism, where the lung disease seemed to have lain dormant, and to have been suddenly ushered into life and activity on the outbreak of the rheumatic attack. The swelling and redness of the joints and other symptoms, though not very severe, were sufficiently characteristic of rheumatic fever to prevent any error in diagnosis, and duly abated under the alkaline and opium or salicine treatment. The occurrence of four such cases in my practice within the space of three years entitles me, it must be allowed, to a reasonable suspicion that there might be something more than chance in bringing about such a coincidence, that a rational explanation might yet be found for the curious fact, and that this might be classed among the many strange and capricious symptoms of phthisis, which often foreshadow with terrible certainty the advent of the dread disease. To understand and rightly interpret these omens is worth something to the practitioner, who has not only to anticipate the contingencies of each individual case that comes under his care, but has a reputation to maintain among his patients for far-sightedness and correct prognosis.

I will now briefly sketch the history of the cases referred to.

CASE 1.—L. M——, a young girl, seventeen years of age, complained from time to time of severe rheumatic pains in the joints of the lower limbs. This is the only case in which redness and swelling of the affected joints were absent. After the pain had lasted a day or two, a copious eruption usually broke out all over the limbs, from the knees downwards, which had the effect of immediately relieving the pain. The eruption was a species of purpura—peliosis rheumatica. The attacks recurred from time to time, followed by more or less of the eruption, the relief from these attacks being always in proportion to the copiousness of the eruption. More than a year elapsed, and the girl was not thriving. The rheumatism to which she had been subject being hardly sufficient to account for the fact, I made repeated and careful examination of the chest, and eventually detected a small area of partially solidified lung in the left side. I expressed an opinion that one of the lungs was affected, and recommended the parents to give her cod-liver oil and iodide of iron. The idea of the lung being affected was such an unwelcome surprise to these people that they consulted another practitioner at once, who attributed matters to delayed menstruation, and predicted a speedy return to health. Within eighteen months this poor girl died of phthisis.

CASE 2.—M. S——, a tall strong-looking young woman, twenty years of age, general servant, consulted me for pain in her back. Suspecting it might have a uterine origin I made special investigation, but elicited nothing to confirm my suspicions, and came to the conclusion, somewhat reluctantly, that it was due to lumbago. A few days afterwards, however, this patient was prostrated on her bed with all the ordinary signs and symptoms of rheumatic fever—knees swollen, red, and painful, ankles and wrists also affected, and temperature increased. Under the administration of salicine these symptoms gradually subsided, and I discontinued my attendance. I had not thought of examining the chest. I heard nothing more of this patient for nearly two years, when I was informed that she was brought home from the South in the last stage of consumption. She died a few months after reaching home.

CASE 3.—C. M. L——, a shepherd's daughter, aged twenty-one, was said to be ill with rheumatic fever. On arriving at the bedside of this patient I was on the alert to discover something more than rheumatism, and naturally directed a

good deal of attention to the state of the lungs; and, as I feared, these organs showed signs of tubercular deposit. Under these circumstances I gave a guarded prognosis, informing the parents that the lungs, and not the joints, were the parts really affected, and that there was some cause for anxiety. It was a difficult matter for the parents, seeing the red and swollen state of the joints, to realise that they were not the sole cause of her trouble. But a few weeks after the abatement of the rheumatism the pulmonary symptoms showed themselves—when the racking cough, the purulent expectoration, and the rapid emaciation made it apparent to all that the poor creature was the subject of advanced phthisis.

CASE 4.—This case, also that of a young woman about twenty-four or twenty-five years of age, came under my notice only a few days ago. I was asked to see her, as she was said to be suffering from rheumatic fever. Her knees were much swollen and very painful. Temperature 101°. I directed special inquiries, with the view of eliciting any symptoms referable to lung disease. She said she had slight cough, but it was from cold contracted a day or two previously, and both she and the attendants repudiated the idea of lung disease, and manifested some impatience at my stethoscopic examination and questions about family history. Respiration was very weak, almost suppressed in parts, rough in others; creaking crepitation heard over both lungs. I prescribed for the rheumatic symptoms, and recommended the friends to administer cod-liver oil, expressing an opinion that her chest was weak. I left the house, wondering that with such a state of the lungs there had not been more decided symptoms. On calling, however, at the next house in that neighbourhood, I was informed that this patient had recently had several severe attacks of hæmoptysis, which weakened her so much that her friends despaired of her life; a fact which they carefully concealed from me.

It will be noticed that all the subjects mentioned here were young females, whose ages ranged from seventeen to twenty-four. Another point worthy of note is the fatal nature of the cases in which this peculiarity was observed. Cases 1 and 2 proved fatal, Case 3 is utterly hopeless, and the prognosis in Case 4 is certainly not favourable; so that this premonitory symptom, if it be a premonitory symptom, must be looked upon as one of grave significance. As for the *rationale* of these cases, I do not think we need go very far to find an explanation of the phenomenon. I venture to suggest that the synovial membranes may be affected to a certain degree by tubercular deposit sufficient to induce a passing inflammation of the joints, in the same manner as other serous and mucous membranes, and that acute rheumatism occurring coincidently with phthisis must be regarded in the same class of complications as meningitis, peritonitis, and enteritis, occurring under the same conditions.

Tongue, Sutherlandshire, N.B.

A NEW METHOD OF APPLYING PRESSURE TO ENLARGED TESTICLES.

BY J. L. CORBETT, M.D.,
SUPERINTENDENT AND MEDICAL OFFICER, LUCKNOW CENTRAL PRISON.

IN the treatment of some of the diseases of the testicle accompanied with enlargement, the practice of applying pressure to the gland is undoubtedly a sound one, and is frequently resorted to by surgeons. I have often wondered that some simpler plan than that of strapping with plaster has not been suggested. The objections against the plaster strapping are numerous. First, it is a tedious business to do neatly and properly. Second, it is dirty both for operator and patient. Third, the operation has to be begun by encircling the neck of the gland with a long strip of plaster. This undoubtedly interferes with the free circulation in the vessels of the cord, and tends to prevent the absorption of the material deposited in the gland. It stands to reason that the freer the circulation in the vessels going to or from the testicle, the more rapid will the reduction in size be from the operation of absorption induced by pressure. Fourth, the strapping loosens very rapidly, and, to be of use, must be reapplied frequently. Fifth, in many cases, even when carefully applied, the plaster cuts the skin and leads to sores. Sixth, I have seen nasty troublesome eruptions on the skin of the scrotum following the use of the plaster.

I have, I think, enumerated enough objections to the old plan, and I will now try to explain the means I would recommend for obviating these objections, at the same time applying a steady, equable compressing force, and one which would also admit of easy regulation as regards the amount of compression. I may preface the explanation of my plan by saying that I derived the idea from a homely source, nothing more or less than seeing the means employed for encasing a football; barring, that instead of having the encasing material made of leather, I would have it made of indiarubber—such as one sees in the construction of the balls in spray producers, &c. The cases I recommend should be made of different sizes and thicknesses, oval in shape (same shape as the Rugby football when inflated). The means of tightening the cases and applying the pressure would be identically the same as in the football cover—i.e., by lacing. There should be an opening at the neck of the case to allow the passage of the cord. This opening would be surrounded by a ring (interrupted) of leaden wire, to ensure its patency and to prevent pressure on the structures of the cord. The leaden wire ring being interrupted, its softness would offer no obstacle to its easy adjustment round the neck of the enlarged gland. With a supply of the cases which I have attempted to describe above, the treatment of an enlarged testicle would offer but little difficulty; it would simply mean the selection of a rubber-case of the right size and thickness, and capable when laced up of exercising a steady equable pressure on the enlarged organs, and applying the case to the testicle and lacing it up. If considered necessary, the testicle could first be enveloped in a thin layer of cotton-wool; this would prevent any possibility of the skin being nipped or chafed by the lacing. As the gland reduces in size a smaller case would be applied, and thus a steady pressure kept up until a cure was effected. The above plan has the advantages of simplicity, neatness, and quickness in its application to recommend it. It involves no elaborate apparatus, and I think does away with many, if not all, of the objections connected with the operation of strapping with plaster. I offer the suggestion in the hope that it may be tried by surgeons at home.

Lucknow.

RUPTURE OF UTERUS CAUSED BY ASCITES OF FŒTUS.

SECONDARY HÆMORRHAGE ON FIFTH DAY; DEATH.

BY A. CHEVALLIER PRESTON, M.R.C.S.

ON Aug. 13th last I was sent for to attend Mrs. D——, aged thirty-five, a multipara, who was then, her friends said, in strong labour. Her previous confinements (six) had been normal ones, but I was consulted by her when seven months' pregnant with this child, about her unusual size. She complained at that time of entire inability to move about, and of a great sense of weight in the pelvis, far more than she had experienced in her previous pregnancies. I examined her then, and found nothing abnormal by vaginal examination, but the abdomen was stretched to an enormous size, and after careful examination I came to the conclusion that it was probably a case of excess of liquor amnii. I gave her a reassuring prognosis, as she was very nervous about herself, and I did not see her again until her confinement. I then found her in the first stage of labour, with the os dilating but slowly, and the head presenting in the first cranial position. The pains being infrequent, and there being no prospect of the case being over for some hours, I left her to go home for a short time. On my return in an hour and a half (3 P.M.) I found the pains had come on more frequently in my absence, and the os was dilating nicely, and half an hour after this was sufficiently so to admit the passage of the head. After waiting another half hour, during which the pains were very violent, and no progress was being made, I determined to rupture the membranes and apply the long forceps. I had an empty four-gallon pail placed under the nates at the edge of the bed, expecting an excess of liquor amnii, and I think the quantity that was evacuated could not have been short of three gallons, allowing for the soakage in the bedclothes, for the pail was considerably more than half filled. I then applied the long forceps without any difficulty, and commenced steady traction with the pains. I succeeded in delivering the head, and during this operation the woman did

not complain of any extraordinary pain. I soon found, however, that on removing the forceps and applying traction to the head itself I could make no further progress, and after a few attempts I tried by grasping the uterus externally to excite contraction to bring the rest of the fœtus into the world. After about ten minutes' waiting, during which time the woman had no pain, though I could feel pretty strong uterine contraction from external pressure, I determined to bring down the arms, thinking this might possibly be a case of obstruction from the shoulders, and with that object in view I passed my hand and brought down both arms and again made traction, but with no better success, and I knew then that the obstruction must be higher up. On passing my hand past the chest of the child, and on through the cervix uteri, I found an enormously distended abdomen, which I knew could not pass through the cervix. Finding this so, I passed a small pair of probe-pointed scissors (closed, of course), which I happened to carry in my pocket, over my right hand, and perforated the child's abdomen as near to the umbilicus as I thought advisable, and a great quantity of serous fluid followed, similar in appearance to the liquor amnii. The patient meantime had a good pulse, with no complaint of exhaustion. Perceiving, however, that my difficulties were not yet over, and that the woman was becoming tired out, after another five minutes' delay, to see if the uterus would contract strongly enough to terminate the labour. I made steady traction on the shoulders, with my fingers under the axillæ, expecting little if any resistance to the passage of a collapsed abdomen through the os. Such, however, was not the case, for in extracting the trunk I felt that something had "given way," as the woman herself cried out, and after separating the child (dead of course) as soon as possible, I passed my hand again, and found a large rent in the cervix, extending three or four inches towards the fundus. I at once detached the placenta without trouble, and finding the woman collapsed and almost pulseless, and tremendous hæmorrhage occurring, gave her a good dose of brandy and ergot, and grasped the uterus externally, and got pretty good contraction. The patient's pulse was meanwhile scarcely perceptible, and the respiration getting stertorous, extremities cold, and the face markedly cadaveric in expression. By dint of hot bottles to the feet, brandy and beef-tea per rectum, and a good firm binder and frequent hand pressure in the uterus, she managed to rally a little and to recognise those around her. I at once gave full doses of opium and ergot, to be repeated every two hours, and gave full instructions regarding the injections, &c. I left her for a little while, and later on met Dr. Nedwill in consultation, and we agreed to continue the above treatment, but he expressed his opinion that the case was then a hopeless one. This was at 3 A.M. on the 14th. She was not losing much blood, there was fair contraction, and the pulse was decidedly improving. We examined the body of the child there and then and found a markedly ascitic abdomen, which, when distended, must indeed have been enormous for a fœtus in utero, and this evidently was the cause of the difficult labour. I saw the patient twice the next day, when reaction had set in. She expressed herself as feeling no pain. Pulse 140, weak; temperature 102·2°. Uterine contraction was good, and she could bear gentle hand pressure, but peritonitis was evidently impending, and in case she should be in much pain I ordered laudanum stupes to the abdomen if required. She was then taking a fair quantity of milk by the mouth, and I discontinued the rectal injections. I passed the catheter morning and evening, and continued the opium and smaller doses of ergot. During the three succeeding days peritonitis supervened, but the woman's general condition did not seem worse. Her pulse was on an average 130, and getting stronger, and she could pass water on the third day. I kept the bowels confined, and continued the opium and ergot. She still took a fair quantity of milk, but none was secreted by the breasts.

On Aug. 19th, five days after her confinement, I visited her in the morning, and found her still gradually improving. Pulse 110; temperature 100·2°. She was cheerful and in no pain, and taking food. Bowels still confined, as I wished to keep her as quiet as possible. I noticed that her aspect had much improved. At 5 P.M. I was hastily sent for and found that she had had a severe flooding in her sleep, and without any apparent exciting cause, for she had been kept perfectly quiet and had not been disturbed in any way. I found her literally saturated in blood, and the case had again assumed an alarming aspect. Collapse had again set in, with pulse almost imperceptible and cold extremities. I gave a dose of turpentine, applied a fresh binder, and stopped the hæmorrhage temporarily. Brandy and beef-tea were given per rectum again, but she died at 9 P.M. No post-mortem allowed.

Remarks.—This case appears to me an interesting one, from the fact of its uncommon occurrence, and from the fact of the patient living for five days after rupture of the uterus. I am anxious to know if many similar cases have been met with, and what is the pathological connexion between excess of liquor amnii and ascites of fœtus. The immediate cause of death was, I believe, due to a large vessel in the ruptured cervix becoming unplugged spontaneously, but had not this happened, I see no reason why the woman should not have recovered. Had I eviscerated, the result would, I believe, have been the same, for it is my impression that the cervix gave way during the passage of the abdomen after the ascitic fluid was evacuated.

Lincoln, Canterbury, New Zealand.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

UNIVERSITY COLLEGE HOSPITAL.

CASES OF PSEUDO-MEMBRANOUS (DIPHTHERITIC) OPHTHALMIA IN NEWLY BORN INFANTS, SIMULATING ORDINARY PURULENT OPHTHALMIA.

(Under the care of Mr. TWEEDY.)

DURING the last two years about a dozen cases have been presented at Mr. Tweedy's *clinique*, which on casual inspection seemed to be ordinary purulent ophthalmia of infants, but which on closer investigation proved to be allied to genuine diphtheritic ophthalmia. In several of these the first peculiarity to attract notice was the disproportion between the degree of corneal complication and the amount of conjunctival inflammation. Inquiry usually elicited the fact that the affection of lids did not begin till a week or more after birth, and that for the first few days the inflammation was apparently not severe nor accompanied with much discharge. An examination of the conjunctiva lining the lids disclosed the presence of more or less adherent and semi-infiltrated pseudo-membranes.

The following case, for the notes of which we are indebted to Mr. W. D. Halliburton, M.R.C.S., ophthalmic assistant, is given as a mild but typical specimen.

Diphtheritic Conjunctivitis in an Infant four weeks old; Quinine Lotion; Recovery.—John G——, aged four weeks, was brought to the ophthalmic out-patient department on February 12th last, affected with great swelling of the right eyelids accompanied with purulent discharge. On Feb. 9th (three days before the visit) the swelling of the lids first appeared, and continued to increase. At the time of admission both lids were very much swollen, tense, and œdematous. The palpebral conjunctiva was smooth, rather pale, and covered with a thin semi-adherent pseudo-membrane. This was detached with a little difficulty, and exposed a smooth and pallid mucous membrane. The cornea was clear and the left eye was unaffected. The case was looked upon as one of diphtheritic ophthalmia, though no history of diphtheria could be made out either as existing in the family or in the neighbourhood. A lotion containing three grains of sulphate of quinine to an ounce of distilled water, and dissolved with a minimum of dilute sulphuric acid, was ordered to be used every hour as a wash for the conjunctival sac, and to be kept constantly applied as a compress to the lids.

Next day the œdema had much diminished, and by the 15th it had entirely disappeared. The conjunctiva on this day was more vascular and more swollen, but there was a suspicion of membrane on the inner part of the upper lid; there was not much discharge, and the cornea was still clear. The lotion was ordered to be continued, but to be used only every

four hours. On the 19th, when the child was next seen, the conjunctiva had a healthier colour, and was more granular; there was no membrane to be seen; the lotion was ordered to be used three times a day. On the 26th there was again a small amount of membrane, this time on the lower lid, the conjunctiva covering the mucous surface of the upper lid was still granular, and no membrane could be seen there. The lids were again somewhat œdematous. The appearance of the conjunctiva, where the pseudo-membrane existed, was very like that which would be caused by painting the surface with white paint. When next seen—namely, on March 1st, both œdema and membrane had disappeared. During these three days the lotion had again been used every four hours.

From this time until March 15th the same lotion was continued, and applied three times a day. Notwithstanding the absence of any visible morbid exudation, the œdema and swelling of the lids disappeared; and on the 15th it was noted that there was slight cicatrisation on the upper lid. The quinine lotion was then discontinued, and a mild lotion of boracic acid (two grains to the ounce) was substituted for it. This was used for a fortnight, when the patient was discharged as cured.

Remarks.—Mr. Tweedy observed that what he regarded as the success of the treatment of this case might not unreasonably foster the belief that the diagnosis was erroneous, and that the disease was not diphtheritic conjunctivitis at all, but rather an anomalous form of purulent ophthalmia. In anticipation of this objection, he called attention to the time at which the disease began, to its one-sided character, to the tense and brawny œdema of the lids, to the smoothness and pallor of the conjunctiva, to the reappearance of the peculiar phenomena when the applications of quinine lotion were prematurely reduced in frequency, and lastly to the sequential cicatrisation. True, it would be easy to overlook the real nature of such a case if it were a unique instance. But this and similar cases could only be recognised and understood by reference to the behaviour of typical examples of the disease. In the most pronounced form the characteristics of diphtheritic conjunctivitis are sufficiently conspicuous to arrest the attention of any moderately observant practitioner. The risk lay in overlooking the milder degrees, which at any time might be aroused into such activity as to lead to the rapid destruction of the cornea. The application of a solution of nitrate of silver, which is almost of essential service in the treatment of ordinary purulent ophthalmia in infants, is almost invariably disastrous when the conjunctivitis partakes of the genuine pseudo-membranous character. Mr. Tweedy referred to a case that had occurred in his own practice a few months before as an illustration of this. Arthur E. H——, aged three weeks, was taken to the hospital for severe inflammation of both eyes on Oct. 9th, 1882. The right eye began to be inflamed when the child was a week old, and a few days later the left became affected. When first seen at the hospital (a fortnight after the beginning of the disease), the right palpebral conjunctiva was covered with thin, sticky, dirty-looking adherent pseudo-membrane; the cornea had sloughed and the iris was prolapsed. The left palpebral conjunctiva had a similar pseudo-membrane upon it, and was but very slightly vascular; the cornea was hazy throughout its whole extent, and had a well-marked abscess at the outer and lower part. Quinine lotion was ordered to be used every hour. Three days later the lids were apparently free from pseudo-membrane and presented the usual spongy, bright-red appearance of ordinary purulent ophthalmia. The cornea was rather cleared and the abscess more circumscribed. The discharge was likewise more purulent. Thinking that the special interest he had taken in the investigation of diphtheritic conjunctivitis might have induced him to exaggerate the gravity of this particular case, Mr. Tweedy adopted the actual indications of purulent ophthalmia and applied a ten-grain solution of nitrate of silver to the everted lids. Though the quinine lotion was continued every hour as heretofore, when the patient was taken to the hospital a few days later the left cornea had sloughed and perforated, and the iris was prolapsed. Had vascularity and swelling of the conjunctiva and the purulent discharge observed at the second visit been taken as an indication of the second or purulent stage of diphtheritic conjunctivitis, rather than as controverting the original diagnosis, the cornea, damaged as it was, might, Mr. Tweedy believed, have been eventually saved by persistent employment of the quinine lotion and by abstention from the nitrate of silver. In further support of the specific character of this pseudo-membranous conjunctivitis, he referred to a case seen in consultation with Dr. John Williams about eighteen months ago. An infant, about a week old, presented the signs of mild simple conjunctivitis, which was treated with weak alum lotion. In about ten days the inflammation had apparently passed off, and the child opened the eyes without difficulty. Suddenly the right lid swelled, and within twelve hours the cornea assumed the appearance of ground glass and became infiltrated at the lower part. Dense infiltrated pseudo-membranes soon appeared on the palpebral conjunctivæ of both eyes. Quinine-lotion was used every hour, day and night, and both corneæ were ultimately saved, though at one time during the treatment the child had suffocative attacks, and it seemed doubtful whether it could survive.

LEEDS GENERAL INFIRMARY.

ABDOMINAL TUMOUR; ASPIRATED THREE TIMES; FLUID CONSISTING APPARENTLY OF ALTERED BLOOD; SUBSEQUENT DISAPPEARANCE OF THE TUMOUR AFTER AN ATTACK OF DIARRHŒA AND COLIC.

(Under the care of Dr. CLIFFORD ALLBUTT.)

FOR the following report we are indebted to Mr. J. F. W. Silk, house-physician.

J. H. M——, aged thirty, a tailor, was admitted on Sept. 7th, 1882, complaining of pain in the abdomen and constant sickness. He gave the following account of himself. About four years ago he first began to suffer from pain in the abdomen, coming on mostly after food, and associated with flatulence and acid eructations. This was put down to ordinary indigestion, and the attack passing off in the course of a couple of months he remained tolerably free from pain up to about five months before admission, when it recurred, and was accompanied by vomiting. At the same time he noticed a hard lump, the size of a closed fist, in the epigastric region, which, he says, disappeared a few days after the other symptoms had subsided. The whole duration of this second illness, including the disappearance of the tumour, was not more than ten days. Subsequently he had three precisely similar attacks, in all of which he noticed the tumour, and in all, except the last, this tumour disappeared in the intervals of comparative good health. The fifth and last attack commenced on June 18th, 1882, and although he was only confined to his bed a fortnight, he never recovered completely, as on former occasions, and the tumour, instead of disappearing as usual, increased in size. The pain and vomiting became more marked about a fortnight before admission, and he lost flesh. The first attack, four years ago, was ascribed to mental anxiety; the subsequent attacks are all associated by the patient with excess either in eating or drinking—e.g., "a heavy supper," "a copious draught of ginger-beer," &c., but beyond that no definite exciting cause can be made out. Both the family and personal history are good. He denied all venereal affections, and, as far as one could make out, there were no signs of syphilis about his person; he has been very temperate, and on the whole has lived a remarkably regular life, free from any serious illness.

On admission he was found to be a highly intelligent man, with an anxious worn expression. The pain obliged him to sit up in bed, and he was constantly vomiting. He retained nothing but fluids, and of those preferred lemonade and other cool watery drinks; he was most free from pain when his stomach was distended with large quantities of such fluids. There were no signs of any excessive emaciation. The layer of adipose tissue was well developed, especially in the abdominal walls, but the whole muscular system was flabby and ill-nourished. On palpating the abdomen, a distinct rounded tumour could be felt occupying the whole of the epigastric region, extending downwards to the level of the umbilicus, and laterally beneath the ribs, inclining rather to the left of the median line. It was elastic and freely movable from side to side; but its connexions, partly on account of the thickness of the abdominal walls, could not be made out with anything like certainty. It did not, however, seem to be attached to either the liver or spleen, which, as far as could be judged from the areas of dulness, did not appear to be enlarged. The deepest inspirations only caused a very slight downward displacement of the mass, and nothing like an hydatid "thrill" could at any time be detected. There was no ascites or cutaneous œdema, and no cardiac or pulmonary lesion. The urine was highly coloured, and contained much mucus. The

temperature was quite normal. He remained in hospital for nearly three weeks, and with careful dieting and complete rest, the urgent symptoms above-mentioned abated, the tumour became less apparent, the urine regained its natural appearance, and the mucus disappeared. He went out at his own request on September 23rd to attend once a week as an out-patient. He was readmitted on Nov. 15th, 1882. Although the vomiting had not returned, and the pain was much less, the tumour had increased in size and had extended a couple of inches below the umbilicus. Its connexions were still a mystery, and even under ether nothing further was made out. While under the influence of the anæsthetic the long fine needle of a small syringe was plunged to a depth of about three inches into the tumour, and about a drachm of dark-brownish viscid fluid withdrawn. This fluid was highly albuminous, but gave no reactions with any of the usual tests for bile; microscopically it showed large numbers of broken-down blood-cells, granules of colouring matter, and some larger and more perfect nucleated cells of an epithelial type, but the most careful search failed to reveal anything in the shape of a hooklet.

On November 30th the tumour was aspirated at a point about three inches above the umbilicus, and thirty-two ounces of a fluid exactly similar to that described above were withdrawn; viewed *en masse*, it had a greenish tinge. Great relief followed the operation, and the tumour became less prominent and tense, although it by no means entirely disappeared.

On December 13th, as the tumour had nearly regained its former dimensions, it was again aspirated an inch below the seat of the former operation, and fifty-one ounces of the same dark-coloured fluid were withdrawn. After this second operation it was noticed that the right side of the tumour had diminished to a much greater extent than the left; so on the 16th another aspiration was performed, the point selected being about an inch and a half to the left of the second puncture. Thirty-two ounces of fluid were withdrawn, resembling in all respects that previously obtained. Immediately after the third aspiration the tumour collapsed, and could only be made out as an indefinite feeling of resistance on deep pressure in the epigastric region, as it did not subsequently increase in size, and the patient's general health was greatly improved. He was discharged on Dec. 26th, 1882.

After his discharge he was seen at irregular intervals as an out-patient, and up to the beginning of March of the present year remained free from pain and vomiting, the tumour gradually reappearing. About the 14th of that month he had a sudden and severe attack of abdominal pain and vomiting; this was followed by diarrhœa, the motions being quite black and loose. From that date, the patient said, the tumour has entirely disappeared, and when seen on May 11th there were certainly no signs of anything like a tumour to be made out in any part of the abdomen; and, except for an occasional feeling of "biliousness," he says that he has been perfectly well ever since March.

Remarks.—The cyst in this case seems to have been composed of at least two cavities, probably communicating, but not freely. The sudden disappearance of the tumour, as if by communication with the bowel, is remarkable; and although one can hardly expect that this disappearance will be permanent, still, from the fact that the tumour is now, after the lapse of two months, quite imperceptible, one is almost led to hope that such may be the case. In every other respect it resembles closely the first of the cases cited by Dr. Bristowe in his "Clinical Remarks on Abdominal Sanguineous Cysts," reported in THE LANCET of May 5th. The case cannot be said to be complete; and the subsequent history of the patient will, as far as possible, be carefully watched; but even in its present incomplete form it presents so many points of interest that it is not, perhaps, unworthy of record.

ST. VINCENT'S HOSPITAL, DUBLIN.

A FATAL CASE OF UNCOMPLICATED ACUTE RHEUMATISM; REMARKS.

(Under the care of Dr. QUINLAN.)

FOR the following notes we are indebted to Mr. Kenna, house-surgeon:—

Kate C——, aged twenty-two, single, of delicate appearance, was admitted on Friday, May 11th, suffering from acute articular rheumatism. She had been ailing for seven days; no previous attack. Both wrists, both elbows, and the left knee were swollen and immovable, and very painful; tongue yellowish white; copious acid perspiration; no cardiac lesion; no subcutaneous nodules. Temperature 103·8° F.; pulse 120. Ordered fifty-grain doses of salicin in milk, commencing at noon; also a quarter of a grain of morphia, hypodermically. At 6.30 P.M. she had taken six doses; the pain of joints was not so severe; temperature 100·8°; pulse 112. Ordered the salicin every second hour if not asleep.

May 12th, 9.30 A.M.: Articular pain completely gone; slept a few hours during the day; temperature 100·5°; pulse 120. Ordered sixty grains of salicin every second hour until evening. 6.30 P.M.: A little articular pain; temperature 101°; pulse 120; the patient restless. Ordered a sleeping draught containing chloral and bromide of potassium. To continue the salicin every second hour.—13th, 9.30 A.M.: Slept well during the night; articular pain gone; heart normal; temperature 100·6°; pulse 128. To continue salicin.—14th, 9.30 A.M.: Slept without a draught; free from pain; heart normal; she is, however, feverish and uncomfortable; intellect quite clear; temperature 100°; pulse 116. To continue salicin. 6.30 P.M.: Temperature 102·8°; pulse 112. At 11.30 P.M. the patient suddenly became delirious and violent. The temperature rose very much; but, as she had to be kept in her bed by the efforts of three persons, it could not be exactly ascertained. She died about a minute before midnight.

Remarks by Dr. QUINLAN.—Having recently put forth some very successful cases of acute rheumatism treated by large and frequent doses of salicin, I feel it incumbent to publish this, the first of a large number of them in which the result was unfavourable. The very high admission temperature, and the frequent temperature exacerbations, marked this case from the beginning as one of those virulent ones that used to be the dread of physicians and an opprobrium to medicine. I am almost inclined to regret that, with this knowledge before me, I did not begin with sixty-grain hourly doses, and adhere to them until the temperature was decisively lowered and the disease evidently subdued. Probably, however, in so virulent a case the result might have been the same. It is remarkable that, although the temperature heightened again and again, the influence of the drug in relieving the articular pain was immediate and complete. Something also might have been done by blistering the epigastrium, a procedure which often does good in severe cases, and that quite irrespective of cardiac complication. The fatal issue does not in the least shake my confidence in salicin. It shows, however, that we have something yet to learn about the exact method of using it, and that we do not yet always administer it with sufficient boldness.

Medical Societies.

EPIDEMIOLOGICAL SOCIETY.

Outbreak of Cholera in Egypt.

AT a meeting of the above Society on Wednesday, July 4th, Dr. J. M. Cuningham, Sanitary Commissioner with the Government of India, read a paper on the "Sanitary Lessons of Indian Epidemics." The President of the Society, Dr. George Buchanan, F.R.S., introduced the subject by the following memoranda concerning cholera:—

1. *Narrative.*—Cholera reached Europe by way of Egypt for the first time in 1865. Before that date, its course from Asia had been through the Russian Empire. At the first appearance of cholera in Europe, over forty years ago, it began in Great Britain fifteen months after its introduction to Europe. At its second appearance, it began with us in England after about the same interval. Its third appearance does not admit of comparison with the others. At the fourth appearance of cholera in Europe, when it came by way of Egypt, it was epidemic in the Hedjaz in May; it appeared at Alexandria on June 2nd; was at Malta, Smyrna, and Constantinople before the end of that month; and appeared in Spain and Italy and at Marseilles during July. Spreading somewhat widely in Europe during the next two months, it was at Southampton on September 17th, and on Nov. 3rd it was witnessed at New York. In the

spring of 1866, cholera acquired an increased diffusiveness; and by June had attacked many places in the United Kingdom, but hardly any cases occurred in London until July. [The Suez Canal was opened in November, 1869.] Extension of cholera from Northern Arabia was next threatened in 1871; and the disease prevailed to a small extent in Europe during 1872 and 1873. Since that date, it has occurred several times among the pilgrims to the Holy places, but has not established itself in Egypt, nor has it prevailed in Europe. Cholera is now at Damietta, a place with some 30,000 inhabitants, about six miles from the mouth of one of the branches of the Nile. The way of its arrival thither cannot be stated. Damietta is not on any high road from Asia; and the towns above Damietta on the Nile are not known to have been affected before this town. No cholera is known of at Suez, nor in the course of the Canal, though from Port Said an occasional death is now being reported. In the ten days ending last Saturday, about 500 deaths from cholera occurred at Damietta; on July 1st there were 140; on the 2nd, 130; and on the 3rd, yesterday, there were 110 deaths. The disease now exists at Mansourah, higher up the same branch of the Nile, and cases are appearing in other towns situated on the railways of the Delta.

2. *Expectations.*—When, I have been asked, may cholera be expected to travel through Europe to England? how long after its present manifestations in Egypt? Evidently no medical data exist for an answer to the question. We do not understand all the conditions for the diffusion of the disease. But we in England do firmly believe, what many of our Indian friends would deny, that cholera is influenced in its spread by human intercourse. We do not affirm that it passes from person to person as small-pox or typhus does; but we believe that it extends much after the fashion with which we are familiar in the case of enteric fever, by means of the discharges from the sick, particularly if those discharges are received into foul cesspools and drains, or if they obtain admission into drinking water; and human intercourse is one of the conditions for the spread of cholera in such fashion as this. If we now, for the sake of hypothesis, suppose other conditions for diffusion of cholera to be to-day what they were in 1865, we may inquire how far the conditions of human intercourse have altered in such wise as to affect the probable dissemination and rate of transmission of cholera in and about Europe. In reply, let it be remembered that, though Egypt has doubtless incurred repeated risk from her communications with the Hedjaz, there is no evidence that even Egypt has been subjected to danger from cholera, at any time, through her direct maritime communications with more Eastern countries; let it be remembered that the Suez Canal has now been open for more than thirteen years; and let it further be noted that the present outbreak of cholera in Egypt is not on the line of traffic between Asia and Europe; and it will appear improbable, I think, that the use of the new highway will affect the course of cholera towards France and England. Still, it is not to be supposed that 1883 will find us in every respect under the same conditions of human intercourse as 1865; and it is possible that some of the changed conditions may be such as to affect the opportunities for the migration of cholera. But, plainly, they are not worth speculating about, in view of our complete uncertainty whether those conditions for the diffusion of cholera which are independent of human intercourse are or are not to be the same in 1883 as in 1865.

3. *Precautions.*—"Quarantine," meaning by the word a system which professes to prevent the entry into a country of persons coming from another country until assurance is attained that no infection can be introduced by those persons, is not now regarded as capable of fulfilling its pretensions; and its least failure to exclude infection is seen to make the whole system irrational; its cost and its vexations unjustifiable. Accordingly, England, which long ago abandoned the system as of any avail against cholera, has now the consent of most European nations (as expressed by their delegates to the Vienna Conference of 1874) in preferring for the defence of her ports another system which, under the name of "medical inspection," aims at obtaining the seclusion of actually infected persons, and the disinfection of ships and of articles that may have received infection from the sick. The details of this system, as formulated for practical application in the ports and waters of England, are set forth in an Order of the Local Government Board of July 17th, 1873. Provision is there made for the detention of ships at appointed places; for the visiting and medical examination of ships and passengers; for the removal to hospital of persons suffering from cholera or suspected cholera, and for their detention there; for the speedy burial of the dead; for the disinfection or destruction of clothing and bedding; and for the purification of the ship and of articles therein. This order is at present operative. From a statement by Earl Granville last night, I learn that it is proposed to reissue the order, though without change in essentials. It represents the system upon which we rely, in preference to quarantine, for the protection of our shores. For the last ten years the country has been thus prepared for the invasion of cholera, and the fact of this preparedness should be known. We have reason to hope that if cholera should enter England it will find fewer opportunities for doing mischief than at previous invasions. We are generally better provided with defences against a disease which spreads as cholera can spread. Some further precautions for use at the moment will doubtless be requisite; but it will be on our permanent sanitary works and procedure that we shall with most confidence rely.

ACADEMY OF MEDICINE IN IRELAND.

Spontaneous Dislocation of the Hip.—Spinal Injury and Muscular Atrophy.

AT a meeting of the Surgical Section held on March 9th, Mr. KENDAL FRANKS read a communication on Spontaneous Dislocation of the Hip, illustrated by two cases which he had himself observed, and of which casts were exhibited. A child, aged five, was admitted into the Adelaide Hospital in January last. She had been confined to bed since the summer of 1882, suffering from "acute disease of the left hip-joint." The acetabulum had chiefly suffered, and the head of the femur had probably passed partially through it, and in that position anchylosis had taken place. An abscess which had formed burst into the vagina, and healed up. The limb remained permanently fixed in a semi-flexed position, abducted and rotated outwards. The child had been chiefly lying on this side, the right leg flexed, adducted, and rotated outwards, so that the knee lay behind the knee of the diseased limb. In August last, as she was being turned in bed by the nurse, a remarkable protuberance was seen behind the right anterior superior spine of the ilium. The child was questioned about it, but could not give any account of how it occurred. It gave rise to no pain. This protuberance was caused by the great trochanter, the head of the right femur having slipped out of its socket, and being easily felt on the dorsum of the ilium. No alteration in the parts has since taken place. The second case illustrated a dislocation of the hip, taking place during an attack of acute rheumatism. A girl, aged fifteen, was admitted into the Adelaide Hospital on Oct. 10th last, suffering from necrosis of the left tibia. She presented a well-marked dislocation of the right femur on to the dorsum of the ilium, the limb being shortened to the extent of 3½ in. In May, 1879, she had an attack of acute rheumatism, from which she completely recovered. In the following February—that is, two years ago—she was attacked again with the same disease, which kept her in bed for ten weeks. The right hip-joint and the right shoulder were the parts chiefly affected. To alleviate the pain pillows were placed under the hip and knees. When she tried to get out of bed after the disease had subsided, she found the right limb considerably shortened, so that she could only reach the ground with the ball of the foot. The right hip was deformed, and she now presents all the characteristic signs of a well-marked dislocation. The head and neck of the bone can be easily identified in their new position, and feel quite smooth and healthy.—Mr. STOKES instanced a remarkable case formerly under his care in the Richmond Hospital, in which a fall was apparently the exciting cause. The patient fell down stairs, sustaining a very severe injury, but he did not apply for advice till a fortnight had elapsed, when it was found he had sustained a dislocation on the dorsum of the ilium, which was, with very little difficulty, reduced by manipulation. Next day, dislocation again occurred, and was reduced; but luxation recurred three or four days in succession. He suggested in explanation that the fracture of the rim of the acetabulum had taken place originally, and a portion of the bone was driven away from its normal situation at the time the luxation recurred.—Mr. BENNETT thought that too much importance was attached to the term "spontaneous." All

pathological dislocations were spontaneous. A more important division would be as to whether the dislocations were complete or incomplete. The term "spontaneous" was a mistake for want of observation. In the deformity in question he would not be surprised if the bones were still intact, but altered in shape.—Mr. FRANKS, in reference to Mr. Bennett's criticism of nomenclature, confessed he had had difficulty in choosing a title for his paper. Perhaps it would have been better had he described the dislocations as simple spontaneous dislocations to distinguish them from disease of the articular surface. He agreed, however, with Malgaigne, that the best line of distinction to draw was between dislocations due to simple relaxation of the ligaments without any disease of the ends of the bone, and cases in which there was caries or some other disease on the head of the bone. Dislocations that occurred from distension of the ligaments formed a distinct group.

Dr. R. MCDONNELL brought before the section notes of three cases of Injury of the Spine, followed by Progressive Muscular Atrophy. In all three cases there was little, if any, loss of sensibility. The patient was sensitive to tactile and thermic impressions. The wasting of the muscles was rapid and set in early after the injuries. The character and appearance, as well as the marked degree in which individual muscles were attacked, showed, in the author's opinion, that muscular atrophy in these cases depended upon the same causes which produce individual muscular atrophy in infantile paralysis and paralysis of the Duchenne-Arun type—viz., myelitis affecting the large motor nerve cells in the anterior cornua of the spinal cord.—The PRESIDENT inquired what were the conditions present in the case that recovered.—Dr. SWAN, referring to the same case, asked the author if he believed that there was regeneration of the cells in the anterior horns.—Mr. WHEELER mentioned a well-known case that was in the City of Dublin Hospital, under the care of Professor Purser, suffering from Cruveilhier's palsy. The patient was a tall gaunt man, who used to stand at Baggot-street Bridge, and had been driver of the Wicklow coach. His upper extremities were only held to his trunk by the levator anguli scapulæ muscles, so that the posterior superior angles of his scapulæ were pulled up close to his ears. He stood with his body thrown forwards, to prevent his abdominal viscera from falling forwards, as all the abdominal muscles had disappeared. The palsy apparently originated from injury. He fell and hurt the back of his neck and spine. From the cast shown by Dr. McDonnell it seemed that the flexor brevis abductor and opponens pollicis muscles were very much wasted. He asked, could Dr. McDonnell assign any reason why the flexor ulnaris muscle and other muscles were not wasted in the same proportion, and if he had made observations in similar cases of the condition of the nerves down the forearm whether their motor fibres were altered. With regard to Dr. McDonnell's second case, it appeared to him (Mr. Wheeler) that the trophic cells were not engaged, but only the connective tissue elements, and when it returned to its normal condition the temporary influence it exercised on the cells ceased.—Dr. MCDONNELL, answering Mr. Wheeler, first as to how the particular muscles atrophied, said in all of those that belonged to the group he was speaking of it commenced in the spinal cord. If a group of those cells disappeared, it might be laid down as certain that the muscle corresponding with that group of cells would also disappear, and the nerves leading to that would wither away. In those cases which he had examined the nerve-fibres in the roots were found to be atrophied. The question was naturally asked, "Might it not begin in the muscle?" or, as Cruveilhier put it, in the nerve-root, or in the trophic cells? Years ago he had himself asked Lockhart Clarke if he had had opportunity of examining cases in which, long after amputations, those cells had not been called into use, and whether for want of use they had become atrophied. It appeared that in fifty or sixty cases which he had examined in Greenwich Hospital the cells in the spinal cord were found to be right. Evidence had been accumulated to show that the disease really began in the nerve-cells and spinal cord.

BEQUESTS AND DONATIONS TO MEDICAL CHARITIES. Miss Agnes Ellis, late of Newcastle-on-Tyne, bequeathed £100 to the Infirmary of that town.—The Royal Hospital for Incurables receives £100 under the will of the late Mrs. Sarah Brown, of Upper Berkeley-street.

Reviews and Notices of Books.

A System of Surgery, Theoretical and Practical, in Treatises by various Authors. Edited by T. HOLMES, M.A. Cantab., Surgeon to St. George's Hospital; and J. W. HULKE, F.R.S., Surgeon to the Middlesex Hospital, and to the Royal London Ophthalmic Hospital. In Three Vols. Third Edition. London: Longmans, Green, and Co. 1883.

THE issue of a new edition of "Holmes's System of Surgery" is an important and welcome event. It has long been recognised as the authoritative exposition of the British school of surgery, and the twelve years which have elapsed since the last edition was published have been so rich in results, both in surgical practice and pathological doctrine, that much in that edition has already become antiquated. Important changes are to be observed in this edition. First and foremost among these we must rank the association of Mr. Hulke with Mr. Holmes, in the work of editing. We need hardly say that this is a valuable acquisition to the editorial department, and that no happier choice could have been made; for Mr. Hulke combines in a remarkable degree a large personal experience with wide reading and extended scientific acquirements. Another alteration is the publication of the work in a cheaper form: the five volumes have been condensed into three, not so much by lessening the length of the various essays, or by the exclusion of essays, as by the use of thinner paper, pages of a larger size, and a smaller type. Bibliophiles will regard this change as a retrogression, but as it will place the book within the reach of a larger circle of readers it has our hearty approval. A period of twelve years has unfortunately necessitated many changes in the authorship of the essays. In some cases the writers for the previous edition are no longer among us, while in others they have associated themselves with younger men, who have re-edited their essays; while in a few instances they have stepped aside altogether, and handed over the entire task to others. Speaking generally, we may say that this edition is of considerable value to the student and practitioner. In every part it bears evidence of most painstaking study and revision, and while in some few cases the restraints of joint authorship and joint responsibility may be traceable, on the whole it is a worthy exposition of the beliefs and practice of British surgeons.

The first volume comprises nearly all the essays contained in the first and second volumes of the previous edition. It opens with M. Simon's article on Inflammation, edited by Mr. Holmes, and Dr. Burdon Sanderson's article on the Pathology of Inflammation immediately follows, which has been rewritten and most carefully brought up to date, so that it forms a very valuable introduction to the whole work. Mr. Butlin has rewritten Mr. Holmes Coote's article on Abscess, and the chapter on Tumours and Cancers previously prepared by Sir J. Paget and Mr. C. H. Moore, and he has also edited Sir J. Paget's article on Ulcers. Mr. Butlin has, of course, considerably modified the article on Tumours in accordance with our increased knowledge of the intimate pathology of these growths, and he has introduced several woodcuts of his own microscopical preparations of many of the chief varieties of tumours. Mr. Cripps has edited but not altered Sir J. Paget's article on Sinus and Fistula, and has furnished one on Gangrene in place of that by the late Mr. Holmes Coote. Mr. Holmes has revised the late Mr. De Morgan's article on Erysipelas, and Mr. Clutton has written that on Pyæmia, including Septicæmia, which was previously from the pen of the late Mr. Callender. Mr. Croft has revised his article on Hectic and Traumatic Fever, and the Treatment of cases after Operation, and has also revised Sir J. Paget's articles on Contusions and Wounds. Mr. Hulke has revised Mr. Poland's article on Tetanus. Mr. Warrington

Haward has rewritten the article on Delirium Tremens. Mr. Savory's article on Scrofula has been replaced by one by Mr. Treves, and that on Hysteria has been edited by Mr. Holmes; but Mr. Savory is still solely responsible for the chapter on Collapse, which has received only a few verbal alterations for this edition.

In the second part of this volume Mr. Holmes has contributed, as before, the articles on Burns and the General Pathology of Dislocations; Mr. Jacobson has written that on General Pathology of Fractures, and has introduced a description of Fat Embolism; Surgeon-General Longmore has revised his article on Gunshot Injuries; Mr. Hulke has edited the articles on Injuries of the Head and of the Upper Extremity; Mr. Jacobson has furnished the chapters on Injuries of the Back and Face; that on Injuries of the Neck is still from the pen of Mr. Durham. The article on Injuries of the Chest was edited by the late Mr. R. Lyell, who also edited Mr. T. Smith's article on Minor Surgery, and wrote that on Plastic Surgery. Injuries of the Abdomen and Pelvis are still, as before, described by Mr. Pollock and Mr. Birkett respectively, and Mr. H. Morris has rewritten Mr. Holthouse's article on Injuries of the Lower Extremity. This volume contains four plates and over two hundred woodcuts, the former all illustrating Mr. Treves's article on Scrofula.

The arrangement of the later parts of the work differs from that of the former edition; thus the second volume contains essays that before were scattered in the third, fourth, and fifth volumes; and Mr. Lee's article on Syphilis, which formerly stood in the first section devoted to General Pathology, is now included, along with his article on Gonorrhœa, in the chapter on Diseases of the Generative Organs—a less scientific but more convenient arrangement. Mr. Hulke has edited Mr. Dixon's article on Ophthalmic Surgery, and has thus been compelled to keep to the lines laid down by Mr. Dixon in the earlier editions. Aural Surgery is described by Mr. Dalby, who has rewritten the article. Mr. A. E. Barker has edited the articles on Affections of the Muscular System and Caries of the Spine, and has rewritten those on Diseases of Joints and of the Tongue. Dr. Brown-Séquard has undertaken the whole subject of the Surgery of the Nervous System; and Dr. Little has revised his articles on Orthopædic Surgery and Scoliosis. Mr. Holmes is still responsible for the essay on Diseases of the Bones, from which we miss any reference to the interesting changes produced in bone by congenital syphilis. Mr. Pollock has again contributed the article on Diseases of the Mouth, Pharynx, Œsophagus, and Intestines. The Surgical Treatment of Stricture of the Œsophagus and the operation of Gastrostomy are, however, more fully discussed by Mr. Durham in the section devoted to Injuries of the Neck. Mr. Warrington Haward has edited and revised the articles on Diphtheria, Croup, and Diseases of the Nose, and Mr. Hensman has dealt in the same manner with Mr. Durham's article on Diseases of the Larynx. Hernia is again treated by Mr. Birkett, and Diseases of the Rectum by Mr. Henry Smith. Dr. Bristowe has revised the article on the General Diseases of the Skin, and Mr. Godlee that on its Local Affections. This completes the contents of the second volume. Scattered through it are two plates and 177 woodcuts.

In the third volume Mr. Holmes has taken the whole subject of the Diseases of Blood and Absorbent Vessels into his own hands either as author or editor, and as he has made this subject peculiarly his own this is a most fitting arrangement. Sir Henry Thompson has written on the whole subject of Diseases of the Urinary Organs, with the exception of a short chapter on Urinary Deposits and Calculi, by Mr. W. F. Donkin. Mr. Hutchinson and Mr. Birkett respectively have revised their articles on the Surgical Diseases of Women and the Diseases of the Breast. Mr. Jacobson has written a very careful article on the Diseases of the Male Generative Organs. Mr. Haward has edited that on Diseases of the Thyroid Gland. Professor Lister has added to his former articles on Anæsthetics, and has revised that on Amputations, and Mr. Holmes has again furnished the article on Excision of Bones and Joints. The articles in the appendix are by the same authors as before, but Mr. Godlee has edited that on Surgical Diagnosis and Regional Surgery, and Dr. Little has edited that on the Surgical Diseases of Childhood, and has added a chapter on Osteotomy. The article on Hospitals has been excluded, and Surgical Instruments are described in various essays instead of in one specially devoted to them. The third volume contains three plates and over two hundred woodcuts, and it is completed by a very full index which has been carefully prepared.

It will thus be seen that the number of those engaged upon this edition has been reduced from forty-two to thirty-six, and that all the surgeons have been or are connected with nine of the metropolitan hospitals with the single exception of Professor Longmore of Netley. It is impossible to examine in any way in detail and critically these three large volumes. The essays necessarily vary much in merit, but we are sure that this edition will be highly appreciated by all who will be at pains to study it.

Lectures on Diseases of the Nervous System. By SAMUEL WILKS, M.D., F.R.S. Second Edition. London: J. & A. Churchill. 1883.

THIS work is an excellent fund of clinical knowledge. In many respects it contrasts with other recent works on diseases of the nervous system. Treating as it does chiefly the clinical aspect of disease, it presents a well-marked distinction from those works which deal with the subject from a point of view of pathological anatomy. A fuller description of some forms of disease, and a more copious illustration by means of clinical reports, have increased the size as well as the value of the book. The lectures are written in a conversational tone, which, however pleasant reading for short periods, to some minds rather palls after a long sitting; and there is a laxity of manner, which, if less impressive, is at all events characteristic. A large mind often cannot stoop, or only with impatience, to departmental detail; the skeletal outline and general configuration of a mental conception may be so vividly grasped that the small undulations which disturb the even surface of the great wave are passed over unnoticed. No doubt this state of mind is of great value in almost every sphere of action; it is in the possession of it that the strength and weakness of the author reside. The classification of spinal diseases which has obtained currency during the past few years has been adopted. As the author suggests, these alterations point rather to pathological considerations than to any great advance in clinical knowledge; nevertheless, the clinical side participates in the reflected light of the pathological.

In the preface to this second edition Dr. Wilks says, "There may often be no disagreement about the case which two practitioners are treating, although they may dissent widely about its pathology." We confess that we are unable to coincide with the view here expressed. If there be no disagreement why is there wide dissension about its pathology? Now pathology strikes at the root of all considerations, and if the practitioners "agree to differ" there is an end of the business; but then it must be regarded merely as an instance of good fellowship, which is really an affair of the emotions and not of the intellect. Even if Dr. Wilks means pathological anatomy rather than pathology proper, we fail to see the full force of his remark.

The section of the work on Diseases of the Spinal Cord is

greatly improved; the improvement has only been rendered possible by the recent advances in our knowledge of morbid anatomy and the study of the various reflex actions.

A chapter on Electricity still exists at the end of the book; the chief features of importance from a point of view of diagnosis are given, the characters of the "reaction of degeneration" are just sufficiently explained. So much has been learnt of late years in nerve physiology and pathology that perhaps a complete work, dealing in a precise and accurate manner with all the various questions, could only be expected from the hands of one who has grown up and developed in the midst of this vast treasure of science.

Manual of Gynæcology. By D. BERRY HART, M.B., and A. H. BARBOUR, A.M., M.D. Edinburgh: Maclachlan and Stewart.

WE have long held the opinion that the writing of manuals is not the province of the junior members of the profession; the several works of this character relating to gynæcology which have appeared during recent years have only confirmed us in our view, and the work before us does not supply grounds for altering that opinion. Although aptitude for teaching is possessed in different degrees by different individuals, yet there is no doubt that special training makes a good teacher just as special training makes a good observer or investigator, and training in teaching is obtained usually only after years of work in observing. The student at the end of his career ought to be, and often is, trained to that point when he may observe and study for himself, but he is far from being an experienced observer, and still farther is he from being an experienced teacher. Long practice in the observation and study of disease, and in the oral communication to students of knowledge so acquired, must elapse before he can become an accomplished teacher. The critical knowledge necessary for the production of a good manual can only be obtained by a long experience in a wide field of observation, so that a manual should be the corner stone of a man's work, his last and best. We should welcome with pleasure the appearance of a manual of the diseases of women by one possessed of the qualifications mentioned; it would prove the greatest boon to the student now so commonly taught to refer all manner of symptoms reflexly to the pelvic organs and to interfere locally with those organs in almost every conceivable condition, be it health or disease. The part for which the training of the junior members of the profession has fitted them is not the writing of manuals, but original investigation, and the work before us supplies abundant illustration of this statement. One of the authors, Dr. Hart, is already well known for the excellent work of this kind he has done in the investigation of the anatomy of the pelvic organs and especially of the pelvic floor, work which forms a material contribution to scientific gynæcology.

The present book is divided into two parts. The first treats of the anatomy and physiology, and the methods of examination, of the pelvic organs. The anatomical portion is very good, being fuller and better than in any other work of the kind. Much of this is Hart's own work, and he is clearly at home in the subject. In the part devoted to the description of the various methods of investigation too much is made of the volsella and the sound. Their value is really limited, much more limited than the chapters devoted to them would lead us to suppose. The values and uses of different specula are not sufficiently pointed out. It might be not unreasonably inferred from the chapter on this subject that their chief use was to discover or conceal lacerations of the cervix.

The second part is devoted to the diseases of the pelvic organs. These are divided into affections of the peritoneum and connective tissue, of the Fallopian tubes and ovaries, of the uterus, of the vagina, of the vulva and the pelvic floor. Three more chapters are devoted to disturbances of the menstrual and reproductive functions and the diseases of the bladder and the rectum, while syphilis and chlorosis are considered in an appendix. A great part of this portion of the work is necessarily compilation, and we can scarcely approve the critical judgment displayed by the selections. The account given of both the pathology and symptoms of the various disorders is generally meagre, while much of the treatment recommended is more injurious than the affections for which it is advised. Such, for instance, are stem pessaries for anteflexion and atrophied and small uteri, Sims' and Simpson's cutting operations for anteflexion and so-called pinhole os. On the other hand, the work contains much that is not found in the ordinary text-books, and this is especially true of the chapters treating of the inflammatory affections of the uterus and the vagina. The work is profusely illustrated; it contains nine lithographic plates, and over 400 woodcuts. Were the book regarded simply as an atlas of gynæcology we should consider it one of the best published; but we have yet to look for a thoroughly good manual of the diseases of women.

Observations on Lithotomy, Lithotrity, and the Early Detection of Stone in the Bladder; with a Description of a New Method of Tapping the Bladder. By REGINALD HARRISON, F.R.C.S., Surgeon to the Liverpool Royal Infirmary. London: J. and A. Churchill. 1883.

THERE appears to be but little more in Mr. Harrison's remarks on Lithotomy than may be found in most of the surgical text-books of the present day. His own experience of the operation has been very good; for of "over forty" cases in which he has performed it he has met with only two deaths—one, a boy eleven years of age, who died of suppurative pyelitis several weeks after leaving the infirmary; the other, "a gentleman of advanced years," who died of "ammoniæmia." The chapter on Lithotrity is in the main a description of Bigelow's operation, which Mr. Harrison has performed twenty-eight times with two deaths—one from cystitis, and one from extravasation of urine occurring from rupture of the urethra behind an old stricture after the patient had left the hospital. Mr. Harrison recommends this operation for children where the calculus is not over three-eighths of an inch in its longest diameter. The author's contribution to the Early Detection of Stone in the Bladder is the suggestion to use in cases of enlarged prostate sounds of different curves, a long copper probe which can be bent to any shape, or flexible bougies tipped with steel. The concluding chapter in this *brochure* describes a mode of tapping the bladder through the perineum in cases of hypertrophy of the prostate. A straight trocar and cannula are thrust into the middle line of the perineum three-quarters of an inch in front of the anus, and pushed on into the bladder through the prostate. In the case in which Mr. Harrison has practised this operation it succeeded very well; for not only was the retention relieved, but atrophy of the gland is stated to have ensued.

Analytical Records.

KREOCHYLE.

A new Liquid Meat, discovered and patented by Prof. F. S. BARFF, M.A., and A. P. WIRE.

(THE KREOCHYLE COMPANY, BIRKBECK-ROAD, LEYTONSTONE.)

A MOST concentrated and active form of liquid food. It contains so much albumen as to become almost solid when heated or treated with nitric acid. It is agreeable in flavour, and this is important, as it must of course be used cold, or only moderately warm. Obviously, it is incompatible with alcohol, which, as is well known, precipitates albumen.

The inventors believe that it can be assimilated without digestion, but we must wait for further evidence before accepting so startling a statement.

LIQUOR ERGOTÆ PURIF.
(C. J. HEWLETT & SON, CHARLOTTE-STREET, E.C.)

Only experience can decide as to the trustworthiness of a preparation like this. All we can say is that it is convenient in form and strength, and as little disagreeable as possible in taste. The high reputation of its makers offers a sufficient guarantee of its quality.

ITALIAN WINES.
(E. VITALI, LONDON.)

We have several times lately drawn attention to the excellent and high-flavoured wines of Italy, so little known in England. The samples now before us, sent by Messrs. Vitali, may serve as good illustrations. They consist of Valtellina, Pomino, Chianti, and Sassella. Of these, Chianti is the only one of which the name is familiar in England, but to our judgment it is by no means the best. We are inclined to give the palm to Sassella—a generous, full wine, with delicate flavour and high bouquet. They are all natural wines, untouched and unfortified, but with good alcoholic strength; and the prices are considerably below that of Bordeaux or Burgundy of analogous quality.

REED AND CARNRICK'S BEEF PEPTONOIDS.
(THE MALTINE MANUFACTURING COMPANY, HART-STREET, BLOOMSBURY.)

This appears to be correctly described as "a concentrated powdered extract of beef, partially digested and combined with an equal portion of gluten." It is a powder, easily made up into beef-tea by the addition of warm water, and agreeable in taste. Of course its value as flesh-forming food is as high as possible, and the work of digestion is aided by the partial peptonisation to which the beef has been submitted.

THE LAIRITZ PINE WOOD PRODUCTIONS.

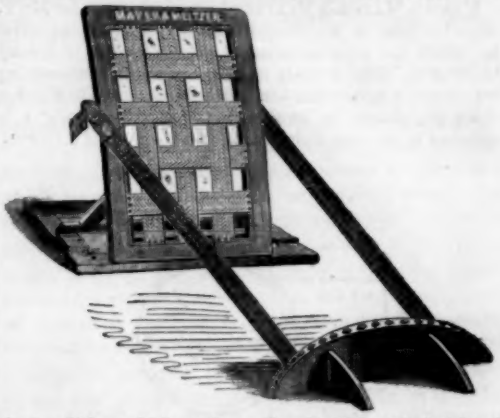
We have received specimens of these new pine wood productions, which are obtained from the bark and comb of the pine tree. They are very numerous, and evidently serve widely different purposes, the list ranging from pine needle extract lozenges to ladies' and gentlemen's under-clothing. The pine wood oil is a clear colourless fluid, having a powerful but by no means disagreeable odour. It is recommended as a local application in gout, rheumatism, synovitis, neuralgia, and many other painful affections. It is stated on the authority of Dr. Gerhardt, of Jena, that it forms an excellent inhalation in winter cough, bronchitis, and even phthisis. The pine wool wadding or flannel worn next the skin would undoubtedly prove of value in patients subject to attacks of subacute or chronic rheumatism. These preparations are as yet comparatively little known in this country, but they deserve attention and a careful trial.

New Inventions.

BED-REST WITH FOOT SUPPORT, AND BED-PAN CAGE.

MESSRS. MAYER AND MELTZER of Great Portland-street have brought out two very excellent invalid appliances which we think are likely to be appreciated. They are both of them the invention of Mr. Newton H. Nixon, the Secretary of University College Hospital, who has evidently been led to devise them from a practical experience of what is needed.

The first is a Bed-rest with foot support, the construction and purpose of which will be at once evident from the accompanying woodcut. When bed-rests are used, the patients are very apt to slip down in the bed, especially when, as is the case in hospitals, there are no foot-boards to the bed. The rest can be maintained at any angle, and the foot-board or stretcher is attached to the rest by pieces of



stout webbing, which can be easily adjusted to the height of the patient. The Bed-rest is very simple and extremely light, and its advantages are so obvious that they need no commendation.

The Bed-pan Cage is quite as simple as the Bed-rest, and should find a place in all hospitals and infirmaries where the excreta of patients have to be preserved for the inspection of the physicians or surgeons. When excreta have to be kept, it is often not advisable to add to them any strong disinfectant which would be likely to destroy their characteristics,

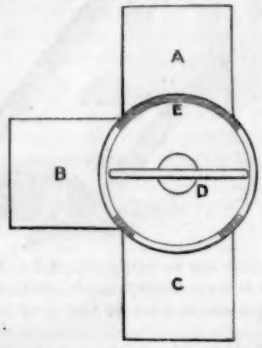
and it is very undesirable to preserve them in the ward or even in the closets adjoining the ward, where the effluvia may be a source of annoyance or even of danger to others. These cages are intended to be fixed in the outside walls of hospitals. In this way, the cages being made of perforated zinc, the fresh air has access to the excreta on every side except the top and on the side of the cage-door which opens into the building. Each cage contains as many shelves as may be deemed necessary, and thus any number of stools may be kept for the inspection of the medical officers, without any inconvenience, annoyance, or danger being caused thereby.

These simple contrivances may be seen among the ap-

pliances of the ward and sick-room which find a place on the shelves of the Parkes Museum.

GAS AND ETHER APPARATUS.

MESSRS. MAYER & MELTZER have constructed for Mr. P. Rhys Griffiths, of the Cardiff Infirmary, a small apparatus by which the administration of gas and ether is greatly facilitated. This consists of three tubes (A B C) meeting together in a cylindrical horizontal chamber (D), in which a valve (E), shown in section, revolves. The tube A is attached to the tube which fits the mouth-piece of a Clover's



ether inhaler; the mouth-piece of the inhaler is fixed to the tube C, and the tube B is fixed to the pipe leading from the reservoir of gas. In the administration of gas and ether, the valve, by means of a handle outside the chamber (D), is made to revolve so that the opening in the tube fixed to the ether apparatus is occluded; the gas is then allowed to pass through the tube B and be inhaled by the patient. As soon as the patient has been brought sufficiently under the influence of the gas, the motion of the valve is reversed, the tube B shut, and the tube A opened; the ether vapour is then allowed to pass gradually through the horizontal chamber to be inhaled by the patient.

ST. ANDREWS GRADUATES' ASSOCIATION.

THE fifteenth anniversary session of the Association was held at the house of the Medical Society of London on June 30th. The treasurer's report showed a flourishing state of the funds. The report of the Council congratulated the members on the avowed intention of the Government to withdraw the clause in the Universities (Scotland) Bill, by which power was given to the commissioners to dissolve the University of St. Andrews; also on their purpose to retain a representative of St. Andrews on the Medical Board for Scotland. Stress was laid on the need of close union so that every effort might be made to retain and to extend the medical faculty of the university; and promise was given of an early meeting to consider the best means of aiding the university and the chairs of the medical faculty by a money contribution from the graduates and their friends.

The anniversary dinner was held in a very beautiful and pleasant room of the Holborn Restaurant, where an excellent meal was served. Dr. Richardson, F.R.S., was in the chair. Among the visitors were Lord Balfour of Burleigh, Sir Joseph Fayrer, K.C.S.I., Dr. Hassall, and Dr. Hayward; and among the numerous graduates present were Drs. Seaton (of Sunbury), Cholmeley, Cleveland, Cooper Rose, Royston, J. Sedgwick (of Bordbridge), Watkins, Murray Lindsey (of Mickleover), Semple, Paul, Hicks (of Hendon), Stamper (of Pembroke Dock), Curgenven (of Derby), Longhurst, and Leonard Sedgwick.

The following officers were elected for the ensuing year:—President of Council: Dr. Richardson, F.R.S. Treasurer: Dr. Paul. Secretary: Dr. Leonard Sedgwick. Council: Drs. Archibald, Alderson, Bynes, Cholmeley, Christie, Cleveland, Corner, Crosby, Dale, A. G. Davey, J. G. Davey, Davies, Gillespie, Gordon, C.B., Griffiths, Henty, Hicks, Hill, Hood, Kesteven, Murray Lindsay, Lipscombe, Longhurst, McMenzies, Professor Pettigrew, F.R.S., Drs. Pocock, Royston, Seaton, J. Sedgwick, Semple, Smith, Stamper, Tibbitts, Wilkinson, Willett, Rhys Williams, and Wyman.

"IS PNEUMONIA INFECTIOUS?"

To the Editor of THE LANCET.

SIR,—There have been several annotations published lately in your columns on the subject of infectious pneumonia, and in the last number of your valuable journal there appeared one giving particulars of two outbreaks of epidemic pneumonia which occurred on the Continent. That such epidemics of this disease take place occasionally gives (as is very truly remarked in the article to which I am alluding), much support to the belief which is now held by many observers in the truly specific nature of pneumonia. Putting aside, however, these well-marked epidemics, a great many medical men must have noticed the suggestive fact that cases of this disease scarcely ever come singly, and sometimes, as I myself have more than once observed, a group of cases may occur in only one geographical direction. During last year I witnessed two instances of what appeared to be communication of ordinary croupous pneumonia by contagion. I will relate them briefly.

In the first case, Ada C——, aged seven, living in a small village, was attacked with pneumonia on April 9th, 1882. The base of the right lung only was affected, the fever did not run very high, and a crisis occurred on April 15th, and was followed by recovery. During her illness she was nursed almost entirely by her father, who was a fairly strong man, fifty-seven years of age, and accustomed to an out-door life. On April 17th he had a rigor, followed by the ordinary symptoms of inflammation of the lung, and he died after an illness of only seven days, on April 24th. The lung mischief was in his case also confined to the right base, and although the temperature never exceeded at any observation 103°, and though he was able to take nourishment and stimulants freely, he showed signs of great prostration from the first, the immediate cause of death being eventually heart failure. I may mention here that there was no evidence of any sanitary defects in the surroundings.

The second case is as follows. Mary W——, aged thirteen, daughter of a farm labourer, came under my care on August 21st, suffering from pneumonia, right base and middle lobe being inflamed. She had a severe attack, but a crisis came on the sixth day (August 26th), and she made a good recovery. On the 3rd of September her little sister Martha, aged three, was seized with inflammation of the left lung. The disease ran a very short course, convalescence being established by crisis on the fourth day. These two cases occurred in a country cottage, well situated, and free from any discoverable insanitary condition.

Of course, in the cases I have related mere coincidence might account for what otherwise is very strongly suggestive of an extension of the disease by infection. I do not, therefore, wish to dogmatically assert that they were examples of contagious pneumonia, though I must express my own firm belief that they were. I hope my publication of these cases may induce other country practitioners to bring forward evidence that may throw light upon this very interesting and important point.

I am, Sir, your obedient servant,

ALBERT E. MAY, L.R.C.P. Lond., &c.

Moretonhampstead, S. Devon, June 23rd, 1883.

SANITARY INSTITUTE OF GREAT BRITAIN.—At the anniversary meeting of the Institute, to be held in the theatre of the Royal Institution, Albemarle-street, on Thursday, July 12th, at 3 P.M., the chair will be taken by Prof. Humphry, M.D., F.R.S., and an address will be delivered by W. Eassie, C.E., F.L.S., F.G.S., entitled "The Relationship between Geology and Sanitation." The medals and certificates awarded to the successful exhibitors at the exhibition at Newcastle in 1882 will be presented at the meeting.

THE LANCET.

LONDON: SATURDAY, JULY 7, 1883.

CHOLERA continues unabated at Damietta, and isolated deaths have occurred at Port Said, Mansourah, and other Egyptian towns. The disease is also rumoured to have come as near to us as the French port of Havre. Whether this turn out to be true or not, it is important that the sanitary authorities of our ports and their officers should know what steps to adopt in case of the arrival of any infected vessel within their jurisdiction. Quarantine, as such, we have happily discarded in this country, and we have no wish to return to a system which would compel a fleet of vessels with none but healthy people on board to lie off our shores for a number of days or weeks merely because they had come from certain ports, or which would require a ship containing a cholera patient to lie at anchor with its complement of passengers and crew until as many as were susceptible had contracted the disease, and this under conditions which would give the hitherto healthy the least possible chance of escape. Where the provisions of the Public Health and the Sanitary Acts against the spread of infection have been duly carried out, other infections have been effectually controlled, even when they have arisen in our midst, and there is no reason why we should not be able to rely at least as fully on the same preventive measures in the case of an infection which can only come from without, and which, before it reaches the community, has to run the gauntlet of what should be an efficient system of inspection in our ports.

An Order issued by the Local Government Board on July 17th, 1873, lays down a code of regulations which should be adopted against the introduction of the disease into our country, and the duty of carrying them out devolves partly on the officer of Customs—a term including any person having authority from the Commissioners of Customs,—and partly upon the Port Sanitary Authority and their officers. The Customs officer has the duty of ascertaining from the master of any vessel whether any person on board is suffering from cholera or choleraic diarrhœa, and if he has reason to suspect that any such disease exists, he has power then and there to detain the ship at anchor, and to refuse access to it to any person except an officer of the Port Authority with whom he at once communicates, for a period of twelve hours. The port sanitary official, whether he has received his information through the Customs officer or not, may require any suspected vessel, or any vessel which has come from a place infected with cholera, to be moored in some appropriate spot selected by the sanitary authority, and there the medical officer of health to the port, or some other qualified medical practitioner, has to examine all persons on board. If cholera or choleraic diarrhœa be discovered, the patients can at once be moved to any hospital provided by the authority, or if either no hospital be available, or the patients are not fit to be moved, the vessel must remain in charge of the port authority, and be subject to such directions as the port officer shall give. On the other hand, all persons found to be in health, and to have no suspicious symptoms, are, after medical examination, free to land immediately; the vessel, together with infected clothing, &c., remaining to be cleansed and disinfected after the last patient has been removed from it.

The above may be taken as a summary of the special action which is needed in view of cholera, and if the disease finds its way into our midst, notwithstanding the precautions specified, we may be certain that it would, as it has often done before, have equally evaded any system of quarantine. These measures are, however, only special ones. The ordinary everyday duty of sanitary authorities, both of our ports and of our inland districts, should be a preparation against infection, whether of cholera, or of any other specific disease, and even at this stage it is not too late to urge on all authorities the removal of all unwholesome conditions which are known to favour the spread of infection, and the provision of adequate means for the immediate isolation of any case of infectious disease which may be imported into, or appear in, their districts. Were these measures universally adopted we could look cholera, and many other infections, calmly in the face, knowing that even if they ventured amongst us, they would soon expire from want of the needed pabulum on which to thrive.

FEW points have received more attention in connexion with the spread of diphtheria than school attendance. It has long been known that children at the school age—namely, from three to fifteen years—were especially susceptible to the disease, but it has been most difficult to ascertain how far this has been due to age predisposition alone, or to special facilities for contracting the infection during school attendance. This question has received special attention in connexion with a series of recurring diphtheria outbreaks at Pirbright, in the district of the Guildford rural sanitary authority, the outbreaks in each case ceasing on the closure of the elementary school, and beginning again when the school recommenced operations. The inquiry was conducted by Mr. W. H. POWER, whose report to the Local Government Board has just been issued.

At an early stage of the investigation it became evident that, in addition to definite diphtheria, there had been in Pirbright a large prevalence of sore-throat, some of it being of a very trivial character, and a house-to-house inquiry was hence instituted with a view of ascertaining the whole circumstances of the throat illness throughout the parish. During this portion of the investigation it transpired that diphtheria had prevailed in the vicinity of Pirbright at the end of 1881 and the beginning of 1882, and that the recent outbreak was in all probability connected in some obscure way with the former one. For seven weeks during the earlier portion of the outbreak now under investigation, the school remained open and the disease extended. It was then closed and there ensued a lull in the disease, the decline being limited to children under fifteen years of age. The school was then reopened for three weeks, and in that period the attacks again became more numerous, the increase being solely amongst children under fifteen years. The school was once more closed, the disease almost disappearing amongst

the children, whereas new cases occurred among older persons. The incidence of the throat illness upon children under fifteen years of age on each occasion that the schools were in working is striking, and, as Mr. POWER says, schools have ere now upon very similar evidence been believed to be the sole propagators of diphtheria. But since children at the school-going ages are more prone to this disease than other persons, this evidence taken by itself cannot be regarded as actually proving school influence as the main factor in the dissemination of the disease, and Mr. POWER therefore set himself to differentiate, if possible, between mere age influence at ages of three to twelve years and any influence that may have been special to the school. The materials thus collected are embodied in a series of instructive tables; and amongst other things it was ascertained not only that children at ages from three to twelve years suffered three or four times more than others in families who were actually invaded with the disease, but also that children of that age not exposed to infection in their own households were in a large proportion of cases those who introduced the disease into their respective families; and Mr. POWER arrives at the conclusion that, apart from its age, the child of three to twelve years has, for some reason or other, been the child to get the disease, and to take it to houses heretofore free from infection. This special influence, he says, must almost necessarily have had to do with the process of school-going. Another table goes to show that in uninfected families children of this special age who were attending school became affected, on the occasion of each school opening, five or six times as numerously as children of the same age who at the same period were not attending school. "While the school remained open in the early months of the year the rate of attack in children from three to twelve years, presumably susceptible of diphtheria, but not having the disease at home, was 16·6 per cent. of those who were at school, and 3·8 per cent. of those who were not." The next time the school was open the respective rates were 4·8 and 0·0, the third time 7·1 and 2·5, and the fourth time 4·1 and 0·0. The subject being further investigated, the same facts are brought out in a different form—namely, in a table which shows what was the occurrence of throat illness amongst this particular class of the community who had no infection in their homes both during periods of school work and school closure, and a comparison of the several periods shows conclusively that the conditions of school attendance must of themselves "have played an important part in the speciality of the incidence of grave illness on children of three to twelve years in Pirbright."

Mr. POWER then inquires what this special school influence was. The sanitary circumstances of the school are discussed in detail; they were of exceptional excellence, and must be dismissed accordingly. Special cleansing measures were adopted on each school closure; hence it is hardly likely that the poison was retained about the school premises. The question of personal infectiveness is next dealt with, and Mr. POWER is inclined to think that this was not the cause of the remarkable difference in the incidence of the disease whenever the school was opened. He refers in this connexion to the extreme care that was taken to exclude scholars from infected houses; he feels convinced that no persons suffering from diphtheria itself or from "notable throat illness" did attend school within five or six weeks of their seizure; and he says that unless persons afflicted with diphtheritic neuroses are to be regarded as infective, it may be doubted whether the infection was on each occasion reintroduced by convalescents. He also fails to find the special influence operating through the schools, in the occurrence of what has been termed the "progressive infectiveness" of the diphtheritic poison; indeed he alleges that each time the school opened multiple cases of diphtheria appeared in startling suddenness and in an aggravated form, without the intervention of cases of a graduated severity.

There are, however, several considerations which prevent us from so readily setting aside this question of personal infection as the principal factor in producing the so-called school influence. Mr. POWER admits that during the course of his inquiry he heard of many cases of very trivial throat affections; he explains how many of these were regarded as mere "colds," the occurrence of which only transpired as the result of close questioning; he says that in regard of families comprising many young children there was noticed a special capacity "of mere sore-throat for breeding malignant diphtheria," and he adds that "in such families severe or fatal cases of diphtheria tended to occupy a position midway in a series of attacks that began as sore-throat and ended in a similar fashion." Now, one has only to regard the children collected at the school as a large family—a simile used by Mr. POWER himself—to conceive that some of the throat attacks which occurred during periods of school closure were so mild as to be absolutely unrecognised, and to accept the inference that the mere sore-throat which bred malignant diphtheria in the smaller families at home produced the same effect in the larger school family when the individuals composing it, once again had opportunity of coming together in a manner and with such nearness of contact as had been impossible during periods of school closure; and then the possibility that personal infectiveness was really the cause which on each school opening came into operation becomes so strong that it can hardly be set aside. The subject is, however, still involved in some obscurity, and we are willing to admit with Mr. POWER that as yet no completely satisfactory explanation of all the occurrences is forthcoming. The report concludes with a few interesting and suggestive details as to the behaviour of diphtheria under special circumstances, and it is throughout one of such substantial value that we cannot close our notice of it without expressing a regret that the precedent recently followed of placing such reports on sale has not been adopted in the case of a document which might usefully find a place in the hands of all who are interested in the etiology of diphtheria.

THE important connexion between the conditions of the renal circulation and the special function of the kidneys lends much interest to the observations made a few years ago by Professor COHNHEIM and Dr. ROY, and now published in detail in the current number of VIRCHOW'S *Archiv*. The method of research was similar to that which enabled the latter observer to make his remarkable discovery of the independent rhythmical contraction of the spleen, and other facts in regard to the circulation through that organ. It

consists essentially in enclosing the organ to be observed within a metal box containing a membranous sac filled with oil, and connecting the apparatus (which Dr. ROY has termed the oncometer) with a recording instrument (the oncograph), whereby the slightest variation in size of the organ can be recorded simultaneously with the kymographic curve of arterial pressure (see *Journal of Physiology*, vol. iii). The instrument allows of such observations being made with least disturbance to the organ, and without interfering with the secretion of urine, and, by registering minute changes, renders the observations more delicate and precise. Under normal conditions the oncographic curve runs parallel with the kymographic; in other words, the systemic blood-pressure and the variations of the volume of the kidney correspond. Changes in the arterial blood-pressure do, however, sometimes influence the quantity of blood in the kidney. If the arterial pressure falls, there is a corresponding fall in the oncographic curve; if it is increased, the volume of the kidney increases. But the reverse is more frequently the case. A sudden sound or movement will cause in the animal a simultaneous rise in blood-pressure, whilst the curve, indicating the volume of the kidney falls; and where the blood-pressure curve is marked by TRAUBE'S waves, the curve of the oncograph is precisely in the opposite direction; the greater the rise in blood-pressure, the more the diminution of the kidney, and *vice versâ*. It was also found that there are apparently primary and spontaneous changes in the renal volume independent of changes in the arterial pressure—a slow enlargement followed by a diminution—occurring in both kidneys, but not synchronously nor to the same extent. An explanation of this singular fact is wanting.

In order to fully test this fact of the diminution in the volume of the kidney coinciding with the rise of blood-pressure, the effects of asphyxia, of stimulation of the sensory nerves and of poisoning by strychnine, upon the renal circulation were noted. The temporary suspension of artificial respiration in the curarised animal is followed at once by a rise in the blood-pressure, which is maintained so long as the state of apnœa is allowed to last. Coincidently with this rise in blood-pressure the volume of the kidney diminishes, the organ returning to its previous size on the return to the normal state of arterial pressure. The rapidity with which this contraction of the renal vessels occurs depends upon the degree to which the blood has previously been oxygenated, the effect occurring the more rapidly the more nearly the blood is dearterialised. The degree to which the renal vessels contract depends also upon the excitability of the vaso-motor system. Thus in one case, where respiration was suspended for 75 seconds, the kidney was reduced in volume 10 per cent.; in another, during a suspension of breathing for 45 seconds, the reduction was 13 per cent.; and in a third observation each kidney was reduced in size 7 per cent. for 30 seconds. Division of the splanchnic nerves had no influence upon this asphyxial contraction, the only effect being that in some cases such division of the nerve caused a slower and feebler diminution in the size of the organ. But when all the nerves supplying the kidney were severed, the kidney enlarged in size corresponding with the rise in systemic arterial pressure. This difference showed that the contraction of the renal vessels during asphyxia was not so much due to the action of dearterialised blood upon the vessel wall as to vaso-motor influences; and it is concluded that the diminution in volume of the kidney during asphyxia depends on two counteracting factors—viz., the elastic tension due to the heightened blood-pressure and the stimulation of the vaso-motorial centre, and as the latter preponderates the kidney is reduced in volume from contraction of its vessels. The differences in this respect between various organs must then be referred to the varying degree of excitability of their vaso-motor nerves. Stimulation of sensory nerves produces similar results. When the central end of the divided sciatic was stimulated, the rise in blood-pressure was accompanied by a very marked contraction of the vessels of the kidney, the size of which was thereby much reduced—a reduction which was maintained for a short time after the stimulation ceased and the blood-pressure had fallen. Here also division of the splanchnics had no influence, whereas after division of the renal nerves the kidney enlarged under the stimulation of the sciatic. Precisely similar was the result of strychnine poisoning so long as the nerve-supply of the kidney was intact.

The generally accepted statement that division of the splanchnic nerves is followed by dilatation of the renal arteries, and consequent increased blood flow through the organ, has not been substantiated by these experiments. Stimulation of the central end of the divided splanchnic at the level of the diaphragm produced a rapid and marked contraction of the renal vessels on both sides, an effect similar to stimulation of the sciatic or other sensory nerves. But an even more marked effect was brought about by stimulation of the peripheral end of the nerve, evidently from the direct irritation of the vaso-motor nerves, the arterial pressure rising at the same time. But the kidney on the opposite side more often than not enlarged in size under such stimulation, and then underwent a secondary contraction whilst the blood-pressure still remained high. At first this was thought to be due to the direct influence of the heightened blood-pressure, when it was found that the degree of secondary contraction was not proportionate to the amount of blood-pressure. It could therefore only be explained by the variable nerve connexions between the splanchnic of one side and the kidney of the other.

The difficulty in the complete division of the renal nerves in the hilus, owing to their intimate connexion with the walls of the artery and vein, throws doubt upon all deductions from such experiments; but when this can be thoroughly effected, then the renal circulation obeys the same influences as the general circulation, and the volume of the organ increases proportionately with the rise in arterial pressure. The results of stimulation of the rena nerves tend to disprove the existence of vaso-dilator nerves, a fact of some importance, seeing how readily the renal circulation is influenced by agents injected into the blood. But the stimulation of either the peripheral or the central ends of the divided renal nerves, whether only one was selected or several, invariably produced a diminution in the size of the organ—i.e., a contraction of the renal arteries.

Some interesting data were also obtained upon the question of the relation between the two kidneys, as bearing on the fact that when one organ is destroyed the other takes on its function, and becomes hypertrophied. The assumption that this is merely due to a collateral

hyperæmia appears to be unfounded, for not only do the kidneys act separately as regards the degree to which they are influenced by changes in the general circulation &c., but it was found that not the slightest influence was produced on one kidney when the renal artery of the other was secured by a clamp. No appreciable change in volume was undergone by the unaffected kidney, although the occlusion of the artery was maintained for periods varying from a few minutes to nearly an hour. Such a result is held to support the view already advanced by COHNHEIM, that the hypertrophy of one kidney after the removal of its fellow depends, not upon changes in the circulatory mechanism, but upon the altered condition of the blood acting directly on the organ. Nor is any renal hyperæmia produced by shutting off the blood-flow from other branches of the aorta. In one experiment both lower extremities were deprived of their blood-supply by the elastic ligature, without any effect being produced upon the size of the kidney either at the time of application of the ligature or on its removal.

Lastly, the experiments of Professors COHNHEIM and ROY tend to show that the generally admitted relation between the skin and the kidney is not so simple as is believed—that it is not a mere question of collateral flux; for in dogs—in which the capability of contraction of the renal vessels had been tested beforehand by the readiness with which they were influenced by stimulation of the sciatic and by intravenous injection of urea—bathing the surface of the body with cold water for some minutes produced either no change in the size of the kidney at all, or only so slight and temporary a contraction as not to be seriously regarded. The statement, then, that the increased flow of urine during exposure to cold is due to dilatation of the renal arteries, coincidently with the rise in the general blood-pressure, is one which will require rectification; and this point is perhaps one of the most fruitful of the results of a method of research which has already thrown much light upon the mechanism of the circulation in the various organs, and which promises to add still more in the way of refutation or confirmation of various accepted physiological doctrines.

INCREASING attention has of late been given throughout Scotland to the desirability of rather radical changes in the law dealing with parochial administration, and in the discussions which have taken place changes are suggested which have decided medical interest. The constitution of parochial boards, though of some political importance, does not immediately concern us; but when, on the one hand, a conference of Poor-law authorities petition for the abolition of the Lunacy Board, and, on the other, a public Society such as the Glasgow Philosophical desiderates the extinction of the Board of Supervision, it appears as if matters are in a very unsettled state. There can be no doubt that, especially in the interest of public health, reform is needed in the Board of Supervision, as at present its whole action and constitution, as well as the relative importance and number of its officers, mark it as simply a Poor-law Board unconcerned with and incapable of efficient control over the public health of the country. Indeed the supervision of the public health in Scotland, except in some of the large towns, is a mere sham; and the reform which is, above all, necessary—viz., the appointment of properly paid and responsible medical officers of health—would impart, as a corollary, a greater weight to the now hardly existing scientific side of the Central Board. Dr. LITTLEJOHN'S rare peregrinations to remote localities where typhoid fever has made its appearance unnoticed by the local officer—who, if there be such an individual, receives £1 per annum with a view to satisfy the letter if not the spirit of the Public Health Act—are the only evidence of the existence of central supervision and scientific assistance. Recollection of the important duties fulfilled by the medical officer of health and police surgeon for Edinburgh will allow of an estimate of the time remaining for the necessary attention to the rest of Scotland. The parochial medical officers are supposed, as a rule, to act also in the capacity of public health officials; but the appointments are frequently omitted, and when the formality is gone through the salary attached is accepted as an intimation that no work is expected. The returns by the Board of Supervision do not afford us information as to the sums received by medical officers of health collectively or individually; but if they did so, it would be found proven that the payments are so insignificant as to be of no consequence whatever. Our frequently ill-paid health officers in England would feel themselves passing rich in the presence of a Scotch official, who for the supervision of a rural parish containing over two thousand inhabitants receives the absurd acknowledgment of £1 per annum. The more courteous of the parochial boards, merely for the purpose of pleasing the Central Authority, make these formal appointments, and no more is heard from either side on the question. It may be confidently stated that the recent advances in the science of hygiene demand urgently that all this should be changed; and a reorganisation of the present system, with the enormous strengthening of the scientific at the expense of the legal element, seems what is specially needed for the modernising of the Central Board.

We fear these are not the wishes which prompt the demand for the abolition of the Lunacy Board. It is rather that parochial and petty interests are supposed to be overlooked by the Commissioners and the Board, with a view to the welfare of the poor creatures under their care. The management of lunacy in Scotland is at present efficient, liberal, and in accord with advanced views; to reduce the whole organisation to a branch of the Board of Supervision, unless this is radically reformed, would be to court perpetual hindrance in the beneficent work of alleviating the lot of the insane. There are many isolated attempts at legislation concerning Poor-law, health, and lunacy administration in Scotland. What seems necessary is a broad and authoritative inquiry into the whole subject, with a view to Government action. Hitherto all higher authority has centred in the Home Secretary and Privy Council; the Board of Supervision has been sufficiently occupied in the administration of the Poor-law; and in no respect has the necessity for a Minister directly responsible for Scotch affairs been more felt than as an important aid to the furthering of reform in health matters. The Bill brought before the House of Commons a few days ago is likely, if passed, to help forward many social improvements in Scotland, and the proposed President of the Local Government Board will have an opportunity of infusing a spirit of activity

in many directions where it is much needed. The present Boards in Scotland do not run the slightest risk of abolition, but with a recognised head over the various departments concentration may be possible, and we may hope that a separate department of public health will commend itself as one of the most crying wants of Scotland.

TWO letters will be found elsewhere in reference to the action of the Home Secretary towards Dr. BLADES, the divisional surgeon, in the case of the policeman SANSOM The letters need little explanation. That of Dr. BLADES explains the whole question between him and the Home Secretary. The case itself will be remembered by our readers. It was indeed a memorable, not to say an unprecedented, case of acute diabetes, in which but five days elapsed between the first application of the patient for medical advice—he being then at work, though wishing for sick leave—and his death. The case was recognised by Dr. BLADES as one of urgency and obscurity, and sent as such to St. Thomas's Hospital, where the patient died on the day of his arrival. No medical man will condemn Dr. BLADES for not fully making out the nature of a case so rare. Even the Home Secretary does not do this, but it will be seen that Sir WM. HARCOURT calls on Dr. BLADES to resign, and on his refusing to do so dismisses him on two grounds: first, that Dr. BLADES on the day preceding SANSOM's death ordered the man medicine, *and did not see that he had it;* secondly, that he did not personally go to the hospital with SANSOM, or send any written statement.

We leave our readers very much to themselves to judge between Sir WM. HARCOURT, who has the chance of being absolute in the case, and Dr. BLADES, who is entirely at the mercy of the Home Secretary. As regards the first charge, it is the duty of a medical man to prescribe medicine; it is the duty of others to see that it is procured and administered. As regards the second charge, Dr. BLADES at least did the next best thing to writing a note or going himself—he sent a verbal message by a superior officer. It is obvious that to a man overpowered with those sudden and mysterious changes constituting acute diabetes it was a matter of indifference whether he was taken personally by his surgeon or by a reliable officer. He was sent to the hospital, where every resource of diagnosis and skill and every comfort were to be had.

We think Dr. BLADES has been very hardly used. It requires but a slight knowledge of the duties of a Police-Surgeon to understand that he must be constantly placed in circumstances of great perplexity and responsibility, in which it is most difficult to judge rightly, between complaining policemen on the one hand and their suspicious superiors on the other. In the premises of the station, too, it transpired that there was an entire absence of arrangements for having the sick treated or for facilitating the detection and treatment of their disease. That Dr. BLADES should have acted for eighteen years without a complaint being made against him is a most significant fact. That he could treat a poor officer so ill as SANSOM or a "brute beast" with inhumanity is refuted by his record in the police service, and will not be credited by anyone who has had ten minutes' conversation with him. Dr. BLADES did well, in our judgment, to leave the entire responsibility of his dismissal to the Home Secretary. We gather from Mr. HOLMES'S note that he regrets the action of the Minister. We could wish that he had entered a more emphatic protest against it as an act of harshness and severity to a good public servant. We are not without hope that the Minister himself will regret his treatment of Dr. BLADES, which is contrary to the wishes, we have good reason to believe, of the great majority of the force itself. Something is due to irreproachable servants of eighteen years' standing. Even the public services cannot injure them with impunity, and when they are harshly judged by a somewhat haughty Minister they might at least expect the protest of their superior medical officer. Dr. BLADES may at any rate rely on the sympathy and unabated respect of his professional brethren, and he may remember with reasonable satisfaction that he leaves the force which he has served so long and so well to their regret, and without having forfeited their esteem.

Annotations.

"Ne quid nimis."

LORD WOLSELEY ON THE MEDICAL SERVICE IN EGYPT.

AT the distribution of prizes at the Charing-cross Medical School on Thursday Lord Wolseley, referring to his past services, acknowledged in warm terms the obligations he had been under in all his campaigns to the medical officers of the army for the zealous and efficient manner in which they had invariably discharged their important and arduous duties. The medical like every other department of the army was affected by the progress made by science, and could not afford to stand still. But while he desired to see some reforms made in it, he must say that no body of officers ever did their duty more zealously than the medical. After the battle of Tel-el-Kebir the wounded were removed and attended to more promptly than, so far as he knew, had ever occurred before, and while he might have fault to find with some parts of the system, he had none to find with the individual officers, whose labours were arduous and very successful. It is satisfactory to know that Lord Wolseley bears such strong testimony to the valuable work done by the medical officers in Egypt, but we cannot help feeling regret that he did not avow these sentiments when under examination before Lord Morley's Committee. They certainly are not in accord with the opinions he then expressed, though perfectly consistent with the reports he forwarded from Egypt, while the events on which he formed them were quite fresh in his mind.

"THE POLITICAL INFLUENCE OF THE MEDICAL PROFESSION."

DR. BALTHAZAR FOSTER, President of the Birmingham and Midland Counties Branch of the British Medical Association, has forcibly directed the attention of the medical profession to its political powerlessness. We agree with him in the opinion that this is a fact to be regretted on public grounds; but we are also strongly persuaded that the fault lies with the profession, or rather with its members. If we are less well placed in England than our professional brethren in Germany, that is because we have not a Virchow. We may have men as capable in themselves, but there is a prejudice in this country against the appearance of practising physicians and surgeons in the political arena. It is not that we are more selfish in our work than our neighbours, but we certainly contend among ourselves more

eagerly, and, as the saying goes, "stick to business" with greater assiduity. It is not for us to say that the purely scientific work of the profession in this country is better than that done elsewhere. Obviously no such plea, if it were raised, would avail for one moment against the force of the argument adduced from the illustrious examp'e of Professor Virchow. Nevertheless it is the fact that, apart from all special considerations, there is a feeling—be it right or wrong, well or ill founded—that practitioners ought not to obtrude themselves too prominently on public notice; and while this feeling lasts we shall not have any great political influence, except that which may be acquired and exercised indirectly. The position as well as the political status of the profession in this country are sacrificed to this idea. It is *consciously* sacrificed. Medical men keep in the background lest they should be suspected of seeking to parade their talents, and, being in the shade both socially and politically, the profession does not, cannot, will not, attract into its ranks the class of men who are born to shine in public. We are each year becoming less social and more exclusive. We specialise technical knowledge, and in its pursuit we form professional habits. Our lives, our views of life, our very natures are special and technical. We must accept the consequences of these characteristics of our mental development. It would take more than three generations to place matters on a new footing. What some one said about a finely timbered estate, and somebody else has applied to the growth of a family of gentlemen, and Darwin has taught of the evolution of species, is true of the medical profession in this country. Before we can hope to obtain the political influence on which Dr. Foster and many others justly set a high value, we must change the direction of the educational and other forces at work in our midst, and set out on a new route. The change is not to be effected by the passing of more stringent protective laws for the profession, by the erection of exclusive departments, like that we have seen constructed in connexion with the Army Medical Service, or by simply returning medical men to the House of Commons. The change needed is a radical one, going right down to the roots of our professional organisation, and laying the bases of a new growth. There is much of sound truth in Dr. Foster's argument, but it cuts both ways, and we must count the cost before we make the change recommended and desired.

AN "ACCIDENT" AVOIDED.

UNDER this or some similar heading the newspapers have recently reported an occurrence which it is difficult to reflect upon with reasonable composure. The driver and stoker in charge of an engine travelling on the direct line of rails in front of the Irish mail, some ten days ago, both fell asleep, and but for the prompt measures taken by two signal-men, who had their wits about them and placed detonating signals on the rails, which awoke the sleepers, there must in the nature of things have been a terrible "accident." We leave it to others to express the thankfulness which all must feel that the calamity was averted. It would have been simply a catastrophe in the true meaning of that much-abused term. The train of events was laid for a fearful event, and by interference only was the sequence prevented. So far as the railway company and its officials—excepting the signal-men whose timely sagacity interrupted the succession of events before the catastrophe—are concerned, responsibility exists as full and grave as though a terrible calamity had occurred; and it is unquestionably a serious defect in our legal system that no provision has been made for such an "inquiry" as the occasion demands. The mere dismissal of the two men who fell asleep will count for nothing. The public have yet to learn that these men were, in a primary sense, to blame for their neglect of duty. It is asserted that the driver and stoker of the engine had been on duty fifteen hours. If this be the fact, it is scarcely strange that they slept. We hold it to be an insult to common sense to suppose that public opinion will be satisfied, or that the indignation which has been, not unreasonably, stirred by this occurrence, can be appeased by the mere notification that the men have been dismissed. It may very well be that these two defaulting servants have been made the scapegoats for getting rid of an offence committed by the Company against public safety. They do not employ a sufficient number of servants, and they keep those they have on duty so long that it is only because the majority of their *employés* happen to be earnest and painstaking men "accidents" are not of quite common occurrence. The present may or may not be an instance of fruit produced by this miserable policy of parsimony. Is it, or is it not, the fact that these men had been on duty fifteen hours at a stretch? In the interests of life and immunity from needless suffering, we press for an answer to this question, and pause for a reply.

CONVERSAZIONE OF THE MEDICAL SOCIETY OF LONDON.

THE annual conversazione of the Medical Society of London was held on Monday last. The rooms of the Society were beautifully decorated, and the new meeting-room, which was used for the first time, was generally admired. At 8.30 Sir Joseph Fayrer took the chair, and called upon Mr. Edward Lund to deliver the annual oration, and at this time the large room was well filled. The orator took for his subject "The Present Aspect of the Antiseptic Question," and while declaring himself a disciple of Professor Lister in both his theories and his practice, he laid special stress upon the fact that certain particular conditions were essential to the development of septic organisms in wounds; and that both those who sought rigidly to exclude such organisms, and those who relied rather upon removing one or more of these conditions necessary for their growth, were alike practising "antiseptic" surgery. A vote of thanks having been accorded to the orator, the meeting-room was quickly cleared of chairs, and the rest of the evening devoted to conversation and an examination of several objects of interest. In the meeting-room was hung the picture of the founders of the Society by Medley, and here Godfrey's band discoursed. In the library Dr. Heneage Gibbes showed some splendid specimens of several varieties of Bacteria under very high magnifying powers, and in one case with electric illumination; Dr. Allchin, the hon. librarian, exhibited some of the older and more valuable of the books in the Society's library, including such treasures as a copy of Servetus on the Trinity, with the earliest reference to the pulmonary circulation; Ward's Diary, with an entry anent the cause of Shakespeare's fatal illness; a beautifully illuminated copy of Petrus Abanus, one of the earliest of printed medical books; and the parish registers of London at the time of the plague. In the Council-room Dr. Spencer Cobbold showed an alarming collection of entozoic parasites of all kinds, from those preying upon the elephant down to those whose habitat is the mouse or the sparrow, and he made a special feature of the parasites causing the grouse disease. Here also was a small, but choice, collection of surgical instruments of different kinds, and Dr. Warner's apparatus for recording graphically the movements in chorea, &c. Mr. Willoughby Smith showed his "inductophone," by which sound is reproduced by means of electrical induction. Several works of art lent by artists and others were on the walls, and in the Library was hung a portrait of Sir Erasmus Wilson, who had presented it to the Society. H.R.H. the Prince of Wales arrived at a quarter to eleven, and was conducted round the rooms by Sir Joseph Fayrer. There was a very large company of

Fellows of the Society and guests—among others Lord Selkirk, Prince Louis Lucien Bonaparte, Sir Richard Temple, Sir Bartle Frere, Sir Risdon Bennett, Sir James Paget, and Dr. C. J. B. Williams; and the officers of the Society are to be heartily congratulated upon so successful an inauguration of their new premises.

PROFESSOR HUXLEY ON THE SALMON DISEASE.

AN interesting lecture was delivered by Professor Huxley at the Fisheries Exhibition Congress on Tuesday last, upon the disease which makes such ravages among fresh-water fish, particularly the salmon, and sometimes in the form of an epidemic. This disease, which is marked by the appearance of whitish patches on the skin of the fish, is attended with great mortality. In the last five years from 2000 to 4000 diseased fish have been taken out of the Tweed, and a like number from the Eden every year. Last year as many as 600 diseased salmon were taken out of a small river like the Leme. On the east coast a few cases have appeared in the Coquet, but none in the Wear. On the Tyne the disease is almost unknown among clean salmon, but it is common with kelts and dace. It may be said that there has been practically no epidemic outbreak in the eastern rivers south of the Tweed. The eccentric course of the epidemic, however, is shown in the fact that on the west coast the state of affairs is totally different, it having made its appearance more and more to the south until last season it broke out in the Usk and Wye. The disease is due to the fungus *Saprolegnia ferax*, which abounds in Irish waters, living on decaying organic matter, but having also the property of attacking living organic matter, so that the wonder is that salmon are not always diseased. Professor Huxley pointed out that it was desirable to ascertain the nature of the influences whereby the widespread sporadic disease suddenly assumes an epidemic character. On this point we have very little light at present, for although there is considerable reason for thinking that deficient oxygenation, whether produced by overcrowding or otherwise, may favour the production of the disease, and though it is probable that some kinds of pollutions may favour it, yet the disease sometimes becomes epidemic under conditions in which these two predisposing causes are excluded. The productiveness of a salmon river is not necessarily interfered with by even a severe epidemic, and therefore Professor Huxley's opinion was that on the whole it were better not to attempt to extirpate the diseased fish. A discussion followed, in which Dr. Cobbold, Professor Honeyman, Mr. Wilmot, and others took part.

A LOCAL GOVERNMENT BOARD FOR SCOTLAND.

THE Bill introduced last week by the Home Secretary, in response to an agitation in favour of a Minister for Scotland, proposes the formation of a Local Government Board for the disposal of Scotch business, which at present is scattered among the Home Office, the Privy Council, and the English Local Government Board. Law and education will not be entrusted to the new organisation, whose president will have a salary of £2000, and may be a member of either House of Parliament. The Home Secretary, in asking leave to introduce the measure, administered something like a cold douche to his own proposals, and evidently feels there is little need for this new departure. Certainly, if the tone of Sir W. Harcourt's speech is carried into the work of the department now to be formed, little benefit will be derived from this shuffling of the cards; but an energetic and patriotic Scotchman will find much to remedy in the many branches of Local Government over which he will hold sway, and ere long work will not be wanting. We may hope that vigour will be imparted to the languid management of public health matters, and at least something will be gained in having an independent and high-placed official to whom appeal may be made for reform when such is so much needed. The work which falls to the proposed department and having medical interest is thus stated in the schedule:—Poor-law, lunacy, registration of births, deaths, and marriages; vaccination, prisons, river pollution, burial-grounds, food and drugs, contagious diseases (animals), artisans' and labourers' dwellings, vivisection, factories and workshops—all at present under the Secretary of State; and public health, now under the Privy Council.

THE PARKES MUSEUM.

THE lecture and discussion on "Hospital Construction" which took place on the evening of the 28th ult. proved to be of great interest and instruction. Although the subject was too vast to be dealt with in more than a skeletal fashion in the time at the lecturer's disposal, yet Mr. E. C. Robins was able to present a general and comprehensive account in a pleasant and lucid manner. Numerous plans of various hospitals, mostly drawn to one scale for the sake of comparison, served to illustrate the lecture. These were hung in almost endless array all round the lecture-hall. After dividing hospitals, according to Dr. Mouat's plan, into clinical, general, special, cottage, and convalescent, the lecturer proceeded to sketch the outline of several home and many foreign buildings for the sick. In the course of the individual descriptions the questions of cubic space, ventilation, cost, and other essential matters received frequent attention. The value of the thermhydric stove invented by Mr. Snell was alluded to. Mr. Robins, in pointing out the beauties and defects of many existing hospitals, was careful to bring into prominence the special features of the pavilion hospital, which, as typified in the Herbert Hospital and the Friedrickshain in Berlin, he considered to be the nearest approach to perfection. An account was also given of the hospital at Antwerp constructed with circular wards. The lecture concluded with an allusion to the shocking state of mismanagement prevalent in the last century at the Hôtel Dieu. In the discussion which followed Dr. Poore confessed himself heretical in many of the matters considered necessary in hospital construction. He did not think one-storeyed pavilions were indispensable. In the newest modes of construction the increased area greatly retarded the carrying out of the administrative duties. Hospitals ought to be regarded not as a single house but as a collection of houses, so that in passing from one part to another open air ought always to be encountered. The evils of vertical staircases and lift shafts inside the main building were depicted as well as the disadvantages of long lengths of extraction shafts for ventilation. Dr. Steele preferred the quadrangular form of building as being easier of administration, of ventilation, and of imparting clinical instruction. Dr. Corfield spoke of the importance of keeping measles, scarlet fever, &c., out of the general ward, and considered that typhoid fever should be served in the same way. Dr. Dawson Williams and Mr. White also joined in the discussion. The chairman, Dr. Mouat, recurred to the originality and importance of the work done by M. Ténon now nearly a century ago. Within the last month he had visited two important French hospitals built on the newest principles by M. Tollet. Notwithstanding the interference of the Assistance Publique at the Hôtel Bichat, Paris, and of the military authorities at Bourges in the new building there, Dr. Mouat was glad to say that the essential principles remained intact, with much benefit to the patients and with clear proof of the value of the advanced pavilion mode of construction. The next lecture will be given by Dr. C. H. Ralfe, at 8 P.M., on July 12th, on the "Hygiene of Schools."

CONVERSAZIONE AT THE ROYAL COLLEGE OF PHYSICIANS.

THE President and Fellows of the Royal College of Physicians gave a conversazione at the College on Wednesday evening last, when they were honoured by the presence of H.R.H. the Duke of Albany and many distinguished visitors, including Lord Chelmsford, Lord Denman, Lord Crewe, the Solicitor-General, Professor Huxley, Sir C. Locock, Sir James Paget, Sir Spencer Wells, and Sir W. Smart. The Fellows and members of the College mustered in full force, and the spacious rooms were filled by all the leading members of the profession. The guests were received by the President, Sir W. Jenner, the Censors, Drs. Munk, A. Clark, Pavy and Garrod, the Treasuer, Dr. Farre, and the Registrar, Dr. Pitman. H.R.H. the Duke of Albany arrived at ten o'clock, and was conducted through the rooms by the President and members of the Council, taking great interest in all the collections exhibited. These included a large collection of fine paintings, drawings, and engravings, Wedgwood medalions, &c., exhibited by Mr. Probert and Dr. Braxton Hicks, who also showed specimens of Berlin cast iron; specimens of Russian enamels, mosaics, &c., by Dr. Meadows; Dr. H. Gibbes exhibited the bacilli of anthrax, typhoid, tubercle, and the fungus of salmon disease; Dr. H. Jones specimens of diseased arteries; Dr. S. West specimens of hearts injected through the coronary artery; Dr. Warner his apparatus for obtaining tracings of the movements of the body. In the small library Mr. Cottrell showed experiments by the electric light in dust and fog. The band of the Royal Artillery performed an admirable selection of music in the hall throughout the evening, which was a complete success.

VERBAL BLINDNESS.

APHASIA presents itself under such a variety of forms, and in such complexity of combination, that there can be no more difficult subject in the whole range of neuropathology or psychology. We have obviously used the term in its widest sense as synonymous with disorder of every kind of the faculty of employing verbal language. The following case of what M. Kussmaul would term verbal blindness is reported at length, but still with insufficient detail in some noteworthy points, in the *Gazette Médicale de Paris* of June 16th. A man of business, aged thirty-five, was suddenly seized whilst in the hunting-field with right hemiplegia and aphasia. He had been the subject of severe migraine, but with that important exception had enjoyed good health. Consciousness was lost a few minutes after the hemiplegic seizure. At no time was loss or impairment of ordinary sensation detected. Both the paralysis and the loss of speech were on the mend when one day the patient wished to complete a letter which he had already begun, and found to his astonishment that he was unable to read what he had written but a few days before. Later on it was discovered that an inability to read printed matter also existed. The letter in question when compared with one dated three years back exhibited no special difference. In talking only occasionally did the patient substitute a wrong word. When seen by Charcot five months after the onset of the seizure, no important defect remained except right lateral hemiopia and the inability to read. The hemiopia had been indicated by the fact that in attempting to play billiards the ball was seen to be but half a sphere. Acuity, however, in the other part of the field of vision was normal, so that the letters could be *seen*, though not read. Loss of memory for a certain number of substantives and proper names, including those of the streets of Paris, existed. He did not venture alone in the city because of the last defect. He could write his name, his address, and even a long letter without any important errors, but he could not read what he had written. In order to decipher a word he slowly formed each letter of the term with the tip of his right forefinger, and then the notions furnished by the movements of the fingers came to his aid and controlled the incomplete, insufficient, visual impressions. In the phraseology of Dr. Bastian, the defective action of his visual word centres was helped out by the almost simultaneous activity of the *kinæsthetic* word centres. M. Charcot has utilised, from a point of view of treatment, the help afforded by this *muscular sense*. So much progress was made that whilst at the beginning of his re-education it took 100 seconds to read one line of print, after sixteen days 27 seconds sufficed to accomplish the same task.

ROYAL SYMPATHY WITH SUFFERING.

THE opening of this hospital on Saturday last, in the finest June weather, was a very happy and auspicious occasion. The visit of the lamented Princess and her children is remembered and mentioned in Eastbourne with much feeling, which finds a fitting expression in the erection of this hospital for the benefit of the poor of the town. The Royal Family is really one of the most useful families in the country. The personal kindness of the late Princess to the poor of Eastbourne has far more to do with the affection of the people for her memory than her exalted rank. The words of the Prince, too, on Saturday, had the ring of real human sympathy in them—that "One touch of nature" which does not, indeed, obliterate distinctions of rank, but at once dignifies and mollifies them. "We have always," said His Royal Highness, "endeavoured to encourage by every possible means any attempts to alleviate the enormous mass of human suffering which must continue to prevail in all very populous centres, and the Queen is ever first among us to take an interest in works of charity and benevolence." These are not formal words; they are justified every week by the enormous personal trouble taken by the Prince in examining and commending institutions having for their object "the alleviation of the mass of human suffering." We are no blind worshippers of His Royal Highness. We respect honest criticism of his character, and even of his faults. He has no easy task before him, standing in the line of succession to a reign so good and so pure; but meantime we feel the value of his right-heartedness and his good sense, and we consider him one of the most hard-working and useful not only of Her Majesty's children, but of Her Majesty's subjects.

BATHING AND CRAMPS.

A SAD instance of fatal cramp from bathing occurred at Durham on Saturday evening last. A fine young fellow, a trooper in the 3rd Dragoon Guards, then on the March from Edinburgh to Manchester, took advantage of the night's halt to have a dip in the Wear near that city. Being strong and a good swimmer, he took an oar, at which he worked for some time in the sultry evening till he came to deep water, and in a suitable place took his plunge. That he was immediately seized with cramp is evident from the statements of his companions, who, alarmed at his cries, hastened to render assistance, but he had sunk before they reached him, and he never rose again. When the body was recovered, a considerable time afterwards, it bore every evidence of the cause of the disaster. It was described as being "twisted"—that is, contorted; while the vessels of the head, especially in their gorged condition, pointed to congestion, in fact to stagnation of the circulation! That this young soldier lost his life by bathing when in an overheated condition is quite clear. It would be well if soldiers and civilians would remember the lesson conveyed in the classical case of Alexander, quoted by Dr. Jones from "Quintus Curtius"—viz., "It was in the middle of one of the hottest days of a burning summer

that Alexander arrived on the banks of the Cydnus. The freshness and clearness of the water invited the King, covered with sweat and dust, to take a bath. He stripped himself of his clothes, and, his body all in a sweat, he descended into the river. Hardly had he entered when his limbs became suddenly stiff, the body pale, and vital heat seemed by degrees to abandon him. His officers received him almost expiring in their arms, and carried him senseless to his tent." The account goes on to show the means taken for his recovery; but it is evident that his life was in great jeopardy from cramp, and that he was just saved by the speedy action of his attendants.

DR. M'CALL ANDERSON ON THE BILL.

DR. M'CALL ANDERSON, in a letter to a Glasgow contemporary, defines the principal object of the Government to be the wish to secure that no one should be licensed to practise who has not passed a satisfactory and complete examination in all the branches of the curriculum. Such a grand object should have had a note of perfect praise from Dr. Anderson, but his happiness seems impaired by the disturbance of the existing machinery, and by the fact that the poor student is to pay for the satisfactory and complete examination. One would think from this compassionate allusion to the student that the existing Examining Bodies were much kinder to him. But are they so? They charge him, and that pretty heavily, and then they do not give him either a complete and satisfactory examination or a complete diploma. Besides, so far as the complete and satisfactory examination to be created goes, it will supersede any corresponding examinations in the existing bodies. There is yet one more cause for anxiety in Dr. Anderson's heart. The action of the Scotch Board—a Board, be it observed, to license for *England*, *Ireland*, and *Scotland*—will be dominated by the Medical Council! Would Dr. Anderson like this arrangement reversed?—would he like the Medical Council to be dominated by the Divisional Board for Scotland. It is disappointing, not to say amusing, when a man of intelligence and reasonableness talks in this way. He knows what powerful reasons there are in the interests of fairplay and of the English public, and in the simple proportion of the population of England to that of Scotland and of Ireland, why in the Medical Council the preponderance should be an English one. It may be gratifying to some who have brought Scotland into great discredit to see such letters as Dr. M'Call Anderson's, but to those who want to maintain the character of Scotch qualifications they are very unsatisfactory.

BOVINE OR HUMANISED LYMPH.

WE have received a communication from Dr. Thomas F. Wood, Secretary to the North Carolina Board of Health, in which he adverts to an article which was recently published in THE LANCET, and which referred to the observations made by several American physicians as to certain advantages attendant upon the system of arm-to-arm vaccination. Dr. Wood is of opinion that the quotation which we made from a report of his does not correctly express his views upon the question as to whether the use of bovine lymph should or should not supersede the use of humanised lymph. Regarded from this point of view we admit Dr. Wood's contention, and we have pleasure in giving prominence to the opinion he has expressed on the subject. Dr. Wood's view is that although there are certain advantages connected with the arm-to-arm system as carried out in this country, "where vaccinations are done faithfully and show excellent results," yet that the advantages attendant upon the use of bovine lymph are still greater, and this mainly on the following grounds:—1. Bovine lymph gives all the results of original vaccinations as described by Jenner and others. 2. This lymph has in his practice appeared to be superior in potency to humanised lymph in cases of revaccination. 3. The tendency of the course of humanised lymph is, after a long series of years, towards degeneration, in so far as its protective power is concerned. 4. Humanised lymph has been known to act as a medium for the transmission of diseases affecting the human subject, whereas no such results are as yet known to have followed on the use of lymph direct from the calf.

THE ABOLITION OF HOSPITAL CHAPLAINS IN PARIS.

WHATEVER the antagonism of the present rulers of France to the national religion of that country, the abolition of the hospital chaplains must be regarded as a most extreme and cruel measure. It is not a question of creeds. It is the deeper question of religion, and of provision for the consolation of sick or dying persons. Violently to withdraw such a provision from the thousands who fill the hospitals of Paris is an outrage on the religious sentiment of the people immediately affected, and of the nation itself. We shall not be suspected of any undue respect for Catholic priests, or their ministrations; but we know what are the susceptibilities and the wants of the sick and of the dying—whether Catholic or Protestant. We know how resolutions for a better life, or considerations favourable to a happier death, may be fostered. In Paris, where the hospital system is so highly organised, the withdrawal of such a provision is more than usually offensive to all good taste and feeling; and we venture to believe that it will be reconsidered. The hospital is not the place to fight the battle of reason *versus* faith, and those who force such a fight in such a field will have the worst of it.

HYPODERMIC INFLATION.

DR. HENRY R. SILVESTER, who has already rendered such valuable services in connexion with the restoration of persons apparently drowned, has been recently making some observations with a view to the prevention rather than the treatment of this condition. It is stated that he was led to this investigation from being brought into contact with the many life-saving apparatus at the Fisheries Exhibition, in his capacity as chairman of jury, Group 7. His method is the artificial production of subcutaneous emphysema. He showed at the Exhibition a small dog, weighing 10 lb., whose subcutaneous tissue he had inflated with air, and which was then able to sustain a weight of 18 lb. in water, in addition to its own weight. Dr. Silvester suggests that a large dog or a calf thus used might be able to bring a number of persons safely to shore, and that there are many cases in which this plan of treatment might be applied to man himself, rendering him practically unsinkable. This is a suggestion that may possibly be of service under some conditions, and is no doubt an addition to the means of saving life at sea; but we question whether more than this can be said about it.

THE DISTURBANCE BY STUDENTS IN THE THEATRE ROYAL, EDINBURGH.

ON Thursday evening of last week a number of students created a serious disturbance in the gallery of the Theatre Royal, Edinburgh. Seven of these were taken into custody; they were brought before the magistrates and fined. A meeting of the Senatus Academicus was held yesterday for the purpose of receiving the report of the Committee that had investigated the circumstances attending the disturbance. There is understood to have been some difference of opinion as to the punishment to be awarded, but ultimately it was determined to rusticate the two chief offenders for the present summer session, which closes on the 29th inst.,

and for the ensuing winter session; while in the case of the other five students who were convicted the rustication was limited to the summer session.

PURE WATER.

IT is one of the primary necessities of life that a full and constant supply of pure water should be available at all seasons, but this is especially necessary in warm weather. At Gloucester, Wrexham, and many more considerable places there is something approaching a scarcity of this necessary. The fault lies in the fact that we have not yet generally perceived the wisdom of making water-supply a business of the State or municipality. It is strange indeed that throughout the cities and towns, with very few exceptions, of this great country, the population is dependent for water on the commercial enterprise of public companies. It may be argued that we are in precisely the same position with regard to our food-supply, yet no one proposes to make that a municipal duty. The conditions of the two cases are not identical. Food is, in a broad and practical sense, a manufactured article. It is true that water also is "manufactured" in the sense that it needs to be filtered; but that is chiefly because the cost of procuring water from its legitimate sources—namely, the deep reservoirs in the earth's crust—is not incurred by trading companies, as it might and would be by public bodies acting solely for the public good. Pure water is only to be obtained from natural sources. Nature has provided a vast system of the most perfect filters and reservoirs, and she maintains these in action. If each community would address itself directly to the task of tapping one or more of the reservoirs which everywhere lie within fairly easy reach, there would be an end for ever of the complaint of our insufficient supply; and the water obtained would be both pure and good.

TRANSPLANTATION OF MUSCLE IN MAN.

HELFERICH (*Archiv f. Klin. Chirurgie*, B. xxviii., p. 562) reports a case in which, as a result of the removal of fibro-sarcoma from the arm of a woman aged thirty-six, the whole upper half of the biceps, with the exception of a thin strand at its outer part, was extirpated. Into the cavity which was left he promptly introduced a large fragment of the biceps from the leg of a dog. The cut surfaces were carefully brought together with sutures, as little injury as possible being done to the parts. The transplanted muscle was much more voluminous than the original portion, and was long after the operation distinctly perceptible to the touch. Electric experiments instituted about three months after the operation showed that the biceps reacted perfectly naturally to both kinds of current. The high point of stimulation situated at the place of section of the musculo-cutaneous nerve was, however, absent. The movements at the elbow-joint were almost normal.

SMALL-POX AND VACCINATION.

IT is often alleged by anti-vaccinationists that nurses engaged in small-pox hospitals escape that disease, not because of the protective influence of the vaccination or revaccination to which they are subjected, but because of their own healthiness and by reason of the healthy conditions under which they are placed. The fallacy of this argument has often been shown, and in a report just issued by the medical officer of health for Newcastle-upon-Tyne—a report we hope to notice more in detail—another proof of this fallacy is afforded. Thus, during 1882, fourteen nurses were engaged in the typhus wards, and of these nine contracted typhus, two of the cases ending fatally. On the other hand, nine nurses were occupied in the small-pox wards, and not a single one contracted the disease. In the case of the typhus infection no preventive was available. In the case of small-pox all the nurses, except one who had had small-pox, were revaccinated; and it is evident that, apart from the protective influence of the vaccination, the nurses were not differently circumstanced as regards susceptibility to infection, for when one of the small-pox nurses was transferred to the typhus wards she caught that fever. The typhus, too, was certainly not of a more infectious character than the small-pox, for, whereas no small-pox patient or other person contracted typhus, two fever patients did catch small-pox. The story, as told by Mr. Armstrong, can only be thrown away on those who are no longer open to reason.

ŒDEMA OF GLOTTIS IN TYPHOID FEVER.

THE occurrence of an acute œdema of the glottis in the course of true typhoid fever is certainly very rare. Beyond its rarity the circumstance is perhaps of no great moment. A young woman, aged twenty-four years, was admitted into the Hôtel Dieu under the care of Professor Vulpian. She had reached the tenth day of the disease, and exhibited in a severe degree all the usual manifestations of the malady. On the fifteenth day albuminuria was discovered for the first time. The next day was of importance, on account of free epistaxis, which was treated by plugging the anterior nares. Since admission till the sixteenth day, six grammes of salicylic acid had been administered daily; now subcutaneous injections of ergotin were resorted to. During the next night a paroxysm of dyspnœa with cyanosis suddenly set in; acute œdema of the glottis was diagnosed, and tracheotomy was promptly performed. Instantaneous relief followed the operation, but lasted only a quarter of an hour, when death ensued from asphyxia. At the autopsy the diagnosis was confirmed in all particulars, and the final asphyxia was found to be due to hæmorrhage into the bronchial tubes, but not proceeding from the operation wound.

THE "LUNATIC POOR (IRELAND) BILL."

LORD SALISBURY was not wrong in describing the speech made by Lord Carlingford, on the second reading of this measure, as "melancholy." It was a hanging defence for the Bill; a friendly kick; an apology worse than condemnation; and, in truth, it is not a Bill to move the heart of any Minister to say much in its favour, even though he happens to have official charge of it. At the same time, it is a measure to be passed as a stop-gap. The condition of the lunatics out of asylums and living with their poor relatives in Ireland is simply scandalous. They are naked, half-starved, and if not actually maltreated, grievously neglected. Far better let them be placed in the workhouse for the time than stay where they are. Workhouses are not well adapted for the retention of imbeciles, but at least they will be clothed and fed in those institutions. However many and great may be the objections to be urged against this measure as a piece of permanent legislation, it ought to be accepted as a stop-gap, and we appeal to the humanity of landlords of Ireland to let it pass.

"VIEWING THE BODY."

SOMEBODY has been trying to induce Mr. Bright and Mr. Chamberlain to take steps to change the law which requires juries to "view" the remains of deceased persons when an inquiry is held. Surely the originators of this most extraordinary proposal can have no precise knowledge of the coroner's special function or court. If the practice of *viewing* were abolished there would be an end of the institution. Everything turns on the discovery of "remains," and the inquiry is one as to those remains. As a matter of fact the scrutiny ought to be more limited, and as it were concentrated, than it is. No other court exists which can take official cognisance of the remains of mortality. Every now

and again the greatest possible service to the cause of justice is rendered by the act of "viewing" when properly performed. Unfortunately it is very seldom indeed that it is performed in anything but the most perfunctory fashion. Jurors take a reluctant peep at the body, or altogether avoid looking at it. This is not the way to perform a public duty. The chief part of the responsibility doubtless rests on the coroner. It is that official representative of the Crown who is charged to "view" the body, but his jury are witnesses of the act he performs, and they cannot be excused their share of the function. To put an end to the practice itself would be to put an end to the court, or so to change its character that it would probably cease to exist.

SIR H. A. PITMAN.

WE are gratified to be enabled to state that, on the recommendation of the Prime Minister, Her Majesty has been pleased to confer the honour of knighthood upon Dr. H. A. Pitman, the Registrar of the Royal College of Physicians, in consideration of his long and devoted labours in the cause of medical education. There is no member of our profession who has more thoroughly earned this mark of Her Majesty's favour. The College in whose behalf he has laboured for a quarter of a century did credit to itself by the vote passed at its last meeting; and this additional honour testifies to the fact that Dr. Pitman's self-denying devotion is recognised beyond the institution with which he is immediately connected.

TOTAL ANCHYLOGLOSSUS.

IF we may judge from a verbal description, M. Duplouy of Rochefort seems to have shown a remarkable case of tongue-tie before a recent meeting of the Société de Chirurgie. The case occurred in a female infant, two and a half months old. The lower jaw was arrested in its development, whilst the atrophied tongue seemed to be everywhere bound down to the floor of the mouth. Suction and deglutition were thereby greatly interfered with, and even attended with attacks of suffocation. As a consequence, the child was ill-nourished, and death threatened unless some relief could be afforded. M. Duplouy proposed to free the anterior part of the tongue by means of the thermo-cautery. Several members spoke on the treatment of the case. Many regarded the employment of the knife, with precautions to prevent a relapse, as the best mode of procedure. Even should such attempts succeed, the tongue appeared to be so atrophied that its value as an organ of deglutition, mastication, and articulation would be considerably diminished as compared with a healthy tongue.

MR. A. H. BENSON, lecturer on Ophthalmic and Aural Surgery to the Ledwich School of Medicine, Dublin, having been appointed an examiner in the Royal College of Surgeons, has resigned, it being a rule that any examiner in the College shall not be permitted to act at the same time as a lecturer. To the vacancy thus created, Mr. John B. Story, surgeon to St. Mark's Ophthalmic Hospital, has been elected by the Medical Board of the School. The lectureship on Medicine, which has become vacant by the resignation of Dr. Foot, has not yet been filled up. For the appointment, Drs. Knight, Cox, Tweedy, and others are candidates.

DRS. REMSEN, MARTIN, and BILLINGS have been elected respectively to the chairs of Chemistry, Physiology, and Hygiene at the Johns Hopkins University. Other professors, it is understood, will shortly be appointed.

LAST week the degree of Magister in Arte Obstetrica *honoris causâ* was conferred by the University of Dublin on Dr. George H. Kidd, of Dublin.

THE *London Gazette* of Tuesday announces that the Board of Trade have received through the Secretary of State for Foreign Affairs the following telegram from Her Majesty's Chargé d'Affaires at Constantinople, with reference to cholera in Egypt:—"Ottoman Board of Health enforce on all arrivals from Egypt ten days' quarantine if free from cholera, and fifteen days if real or suspected cases on board. There is, further, a medical inspection at Dardanelles. Quarantine to be performed at Smyrna or Beyrout for vessels bound to Mediterranean Turkish ports; those for Red Sea ports go to Camaran."

CLINICAL medicine and surgery would appear to be at a low ebb in Melbourne, or rather to have no existence at all. The lecturers on Medicine, on Surgery, and on Obstetrics have not, it seems, a single bed set apart for their use in any of the hospitals. The medical faculty in the University have complained to the Council on this matter, but hitherto without effect. If hospital tuition, as a part of the medical curriculum, is to be anything more than a name, clinical instruction must be forthcoming.

DR. DYCE DUCKWORTH and Dr. SYDNEY JONES, of Sydney, have been appointed delegates to represent the colony of New South Wales at the forthcoming International Colonial Medical Congress to be held in Amsterdam in September next.

ON the 19th inst. the Council of the Royal College of Surgeons in Ireland will elect from among the Fellows an examiner for the diploma in Dental Surgery. The vacancy has arisen in consequence of the death of Mr. B. Wills Richardson.

THE Dean of Llandaff (Dr. Vaughan, Master of the Temple) will take the chair at Dr. Ralfe's Lecture "On the Hygiene of Schools" at the Parkes Museum on Thursday, July 12th, at 8 P.M.

CONFERENCE ON THE ADMINISTRATION OF HOSPITALS.

ON Tuesday last a conference (convened by the National Association for the Promotion of Social Science) was held in the hall of the Society of Arts, on the subject of the administration of hospitals; Sir T. Fowell Buxton presided.

The CHAIRMAN, in opening the proceedings, said that during the past ten years there had been a great deal more active thought and criticism brought to bear upon our hospital system than formerly. Before that time there was perhaps fully as much ready self-sacrifice and willingness to give and to devote time and attention to the administration of each hospital. Men were loyal to their own hospital. Little attention was given to the mass of necessity which had to be relieved, while a great deal was given to the particular machine which was relieving necessity in a particular sphere and a particular area. During the last ten years, however, a great deal of fault had been found, and a great deal had been said to show that what had to be done was very far from being done properly. Men had contemplated large areas, and said, "Here is no supply for the relief of sickness or distress," or they had found that for certain classes there was a very deficient supply, while for others the supply was ample. Among the more active reasons that had led to this increased consideration of the whole question two or three stood out prominently. One of the first and foremost had been the need of increased funds. There had perhaps been two causes working in this direction. It might be that the standard of what ought to

be supplied to each patient had increased; but at all events there had been a greater expenditure. At the same time many hospitals had found that there had been a falling off in the supplies. The British public was not less willing to give than formerly, but there were many new channels in which the subscriptions flowed. The result had been that many hospitals experienced greater difficulty in raising the funds which they required. That had been, perhaps, the chief reason why those connected with the administration of hospitals had been led to consider the subject as a whole, and to inquire how, in the future, the funds were to be supplied, and that had led to a consideration of the best mode in which hospitals should be governed. It had become evident that the system was in itself incomplete. In the north and east of London there were large areas and vast populations altogether unsupplied, or very poorly supplied, with the medical relief which was given in hospitals, whereas within a very short radius of the hall in which this conference was now meeting there was an enormous proportion of beds. This state of things had led some people to ask, "Ought there not to be some central body to determine what way the demand should be met? and is it not possible to set up one central government which should decide not only where hospitals should be placed, but how they should be governed?" The idea of holding a conference occurred to some members of hospital committees, and others connected with them, five or six years ago, when Mr. Burdett wrote a suggestion of the kind to *The Times*. In 1879 a few gentlemen met at his (the chairman's) house, and came to the conclusion that it was very important that a Royal Commission should be appointed to consider many of these questions, and to report on the supply of hospital relief to the population of London. Since then the subject had been discussed before the Social Science Association. These facts showed that a great deal of interest had been felt of late years in these matters: and he had no doubt that good would result from the papers and discussions at the present Conference.

Mr. F. POWELL, after alluding to Mr. Burdett's paper read before the Social Science Congress at Dublin, said it was felt that so important a subject could not be allowed to remain in its then position, but that some action ought to be taken. A committee was appointed to consider whether some further steps should not be taken with a view to the complete investigation of the whole subject of hospital administration. A paper of considerable length was prepared and submitted to the Home Secretary, with a request that he would receive a deputation on the subject of the appointment of a Royal Commission. The deputation was, however, not received, and the petition for a Royal Commission met with a refusal.

A paper was read on the subject of the "Governors and the Management of Hospitals, and the Selection and Appointment of Committeemen," by Mr. B. RAWLINGS, Secretary of the National Hospital for the Paralysed and Epileptic. The following are the principal suggestions contained in the paper:—The first need is to eliminate from committees the elements of vacillation and unreality and to render them robust and stable. A model committee might be constituted thus: a medical member; a legal member; a member with actual experience of executive management as an ex-treasurer or ex-house governor, and two or three men of business with special inclination for the work. Merely ornamental members ought to be rigidly excluded, and it would not be too much to ask of those who undertake the duties an explicit engagement to perform them. Vacancies should be filled with due regard to the place the retiring member has occupied, so as to maintain unimpaired the structural constitution of the committee. Under such conditions there should be no dearth of aspirants, and to be a member of the governing body of an important hospital ought to confer an honourable distinction. Efficiency will be promoted and sustained by an ampler sense of personal responsibility, and this in its turn will be secured by a concentration and fuller evidence of authority. We want such a process of evaporation set up by the application of more stringent conditions as will carry off the volatile elements and leave behind all that is essential. A hospital needs the niceties of personal government stimulated and controlled by a sense of public accountability. A small highly organised committee of the kind suggested, constantly equipped for service, containing in itself the sources of such knowledge and experience as are needful, its members mutually advising and bound together by an ardent solicitude for the welfare and utility of the institution they serve, with a chief officer working with them and under them, would prove more effective than all the elaborations of councils and courts ingenuity has devised.

A paper was read on "The Best Forms of Executive Government," by Dr. J. S. BRISTOWE. The paper dwelt mainly on the experience of the new mode of management adopted at St. Thomas's Hospital, which is governed by a house committee, consisting of the treasurer, almoners, and six governors, including two gentlemen who have been physicians or surgeons of the hospital. The best results, Dr. Bristowe stated, had followed the appointment of this committee. No unpleasant feelings or difficulties of any importance had arisen between the governors and the medical staff. It was formerly supposed that there was antagonism between the medical staff and medical school and the nurses and the nursing school; but that feeling had been wholly dissipated since the appointment of the house committee. It might be thought that it would be better to allow all members of the staff to attend the house committee, but he was not of that opinion. He had been told that where such a method was adopted there was a tendency for the medical staff to sit upon the other members of the committee and to overbear them. It was not desirable that the medical members of the committee should have the power of voting. His own experience was that he had never failed to carry his point when he was obviously right. He highly approved of the constitution of the committee at St. Thomas's. The only point in which he thought it might be improved was the relation of the medical members to the staff and school. He thought that instead of being appointed as at present by the treasurer, they should be elected annually by their own colleagues.

Dr. TIBBITS, of the Bradford Infirmary and Fever Hospital, said that at that institution the medical staff took their seats at the board of management, and two of them in rotation annually attended the house committee. He suggested that hospitals might be managed like a railway company, by a general manager, with submanagers for the different departments, and he contended that every member of the working staff should be paid.

Mr. BOUSFIELD, a member of the Committee of the King's College Hospital, said that the unanimity existing on that committee had arisen largely from the fact that a large proportion of the medical men were members of it. To secure good hospital management there must be proper responsibility, and that could only be carried out by a limited number of persons responsible for good government. Government control, he thought, would be disadvantageous in preventing or checking the adoption of improved methods. The annual meetings of governors were sometimes a farce; but it was necessary that some matters should be submitted to popular opinion, which could only be done by means of such meetings. It was impossible to adopt a theoretically perfect system, and the only thing to be done was to secure the best practicable method, to be improved from time to time by those who had to carry out the management.

Mr. H. MAUDSLEY, who stated that he was connected with twenty-six London hospitals, considered that unless the subject of the administration of those institutions was carefully examined and dealt with they would be absorbed by the Government, a result which he strongly deprecated.

Dr. ALEXANDER, of the Western Infirmary, Glasgow, said most of the committee of management of that institution were appointed at the annual meetings of the qualified contributors. In addition to these there were representatives from the Medical Faculty and the Senate of the University, and other public bodies. They met monthly. There were various subcommittees. The medical members of the staff were not on the committee, but on any question affecting them they were always consulted. A medical superintendent was responsible for the whole of the government of the hospital. All the appointments to the medical staff were made by the managers, so that there was no canvassing of the contributors. The large hospitals in Aberdeen and Edinburgh were conducted practically in the same manner.

Rev. E. BIRKETT, of the West of England Sanatorium, suggested the following plan for the government of hospitals. First, there should be a small executive committee not exceeding seven members, upon which the medical staff should be adequately represented. To prevent the tendency of such a committee to become a close body, a board should be formed consisting of the vice-presidents and a certain number of elected members, to whom appeals should be made on all

important questions of change of policy or extension, and on all matters beyond the ordinary routine of hospital management. That board should elect the executive committee, and the election should be by ballot.

Mr. JOSEPH WHITE, Surgeon of the Nottingham General Hospital, said that at that institution general questions were submitted to a board of governors consisting of all subscribers to a certain amount. A weekly board took the management of the house, and there was an independent medical board which controlled everything connected with the treatment and welfare of the patients.

Mr. H. BURDETT, Queen's Hospital, Birmingham, after expressing his belief that a successful medical school meant a successful hospital, spoke against the practice of holding an annual dinner in connexion with hospitals, and cited an instance in which the holding of an ordinary meeting instead of the dinner had been attended with the best financial results. With regard to the election of the medical staff, he preferred that adopted by the Birmingham hospitals—viz., election by a special committee appointed by the rules consisting of all the members of the committee of management and of the honorary staff, with a certain number of governors selected by ballot. The best representation of the medical staff on the committee of management was, he believed, the election of two delegates by the medical staff.

Mr. LEIGH GREGSON, Southern Hospital, Liverpool, said the general committee at the hospital consisted of twenty-five members, out of whom ten were elected as a board of management. The general committee met once a month, the board of management once a week. Two visitors were appointed, one from the board and another from the committee, to go round the hospital almost daily and see that everything was regularly attended to. There was also a medical board, the chairman of which attended all the meetings of the board of management.

Mr. GEORGE LLOYD, General Hospital, Birmingham, said he had come to the conclusion that just as the public asylums and elementary schools had come under local management, so hospitals must pass from being private institutions to municipal management in the boroughs, and to the management of county boards (when they were established) in the counties. In almost every other English-speaking country the hospitals were not private affairs, and this result was arrived at, that about twice as many beds were provided in proportion to the population as in England. Tickets for free admissions were also get rid of. The General Hospital, Birmingham, had existed more than one hundred years, and there had been no quarrels worth speaking of, nor was there ever any great lack of funds. A committee of about fifty was chosen once a year by subscribers of two guineas, and every honorary medical officer was a member of the committee, as well the president and vice-presidents. The committee met once a month. From them were appointed three subcommittees—the house committee, the finance committee, and the medical committee. The medical gentlemen chose two members of the house committee, who practically managed the institution. Six visitors were appointed who were not members of either of the committees. The working men of Birmingham collected £5000 a year for the charities of the town, and they claimed to have representatives on the committees.

Mr. GILMAN, of Baltimore, gave some particulars of the method about to be adopted in the management of a new hospital in the course of erection in that city. The government would, he said, be in the hands of twelve men, with an executive committee, and each department of the hospital would have a special manager.

After a short adjournment, a paper was read by Mr. TIMOTHY HOLMES on the question, "Can the System of Free and Pay Beds and of Payment by Out-patients be successfully applied to existing Hospitals?" While approving of the change recently carried out at St. Thomas's, Mr. Holmes thought it was in some respects faulty; and he urged that if paying patients are to be admitted to hospitals having medical schools, they must not be withdrawn from the observation of the students, a change which would involve the remuneration of the medical officers who attend the paying patients. As to out-patients, he saw no reason why such cases should be treated on the paying system, unless as consulting patients. To create a large department of people who would come for sixpence a time, would be to introduce an abuse greater than those it was sought to abolish. A plan like that of the Medical Provident Association would provide for the great bulk of ordinary out-patients. There would remain the cases which required consultation, and those would come to the hospital—gratuitously to those with medical schools, and to the others on terms which could be easily fixed.

A paper on the same subject was read by Mr. J. S. WOOD, Honorary Secretary of the Bolingbroke House Pay Hospital, and Secretary of the Chelsea Hospital for Women. The author strongly advocated the contributing system, and stated that, in 1881, £28,909 was received by the various hospitals, convalescent homes, and medical institutions from the payment of the patients. The following were the percentages and payments made by patients (at those hospitals which now received them) to the gross cost of maintaining all hospitals which share the Hospital Sunday Fund:—1879, 3·40 per cent.; 1880, 4·08 per cent.; 1881, 3·99 per cent.; 1882, 3·97 per cent. At 7 general and 28 special hospitals the paying system was practised in one form or another. Of the London general and special hospitals, 12 adopted the free system only; 9, the letter system only; 6, the contributing system only; 13, the free and letter systems; 21, the letter and contributing systems; 10, free, letter, and contributing systems; 2, free, contributing, and voluntary systems; and 3, free and contributing systems.

Another paper on the same subject was read by Dr. FAIRLIE CLARKE, late Assistant-Surgeon to Charing-cross Hospital. The author advocated the payment system, and recommended a sifting and classification of applicants for out-patient relief. Those who could not afford anything he would have treated gratuitously; the number, he thought, would, after a time, become very small, and they would receive more individual and liberal attention than was now possible. Of the rest it would be found that some could afford to pay the charges of a general practitioner, while the great majority could pay according to the scale adopted at provident dispensaries. The present free dispensaries might with advantage be converted into provident dispensaries, where the medical officers would receive a salary in proportion to the number of cases treated. Wherever the provident system had had a fair trial the working classes had shown themselves very ready to adopt it. The author referred to the experience acquired at Croydon and St. Alban's in support of his position.

The next paper was on "Hospitals in connexion with Provident Dispensaries," by Mr. A. G. HENRIQUES, the object of which was to set forth the advantages of the system of medical relief introduced by the Metropolitan Provident Medical Association for the establishment of provident dispensaries throughout the metropolis. That method, the author maintained, is the best remedy for the evils attending the present out-patient system generally pursued at hospitals. Since 1880 nine provident dispensaries had been established through the efforts of the Association, or existing dispensaries had been taken over and adopted. Out of that number only three are self-supporting, but three others are expected to become so in the present year. The number of members required to make a dispensary self-supporting is about 1000. The scale of payments is for members of benefit societies 4*d*. per month; for non-members 6*d*. per month; for a whole family, including children under sixteen, 1*s*. per month. The success of the system, the author states, has been less than was anticipated, in consequence of the first-class gratuitous medical attendance provided at the hospitals for the artisan class. The out-patient department at hospitals, he thought, ought to be limited to accidents and surgical cases.

Sir CHARLES TREVELYAN thought the main source to be looked at for the relief of the over-burdened hospital system, not merely as regards out-patients, but also in-patients, was the organisation of an efficient system of provident dispensaries. The medical treatment of the vast population of London was far greater than private charity could deal with, and it had broken down not only financially but administratively. Working men could not pay large professional fees, but the difficulty could be solved by applying the principle of association, co-operation, and mutual assurance upon which the great friendly societies were based.

Lord CORK said it had been stated that the object of many of the hospitals in getting a large number of out-patients was to obtain subscriptions from the general public, but so far as St. George's Hospital, at all events, was concerned, that was not so. There each medical man was limited to fifteen or sixteen new out-patients each day, so that fair time and attention could be given to every case, and the

poor had their wants amply looked to. No doubt provident dispensaries would very much assist in getting rid of many of the out-door patients in the large hospitals, but how could the board of a hospital discriminate between cases which ought to receive free relief and those which were capable of paying for their own relief? How were the provident institutions to be worked and paid for? It appeared that there were only three in the metropolis that were self-supporting, and therefore the others must receive support from the public, in which case they would take away subscriptions from the large general hospitals.

Mr. JAMES CROPPER, M.P., was of opinion that with regard to the hospital system, redress for the difficulties which now exist must be found in coming down to the people themselves. It was beginning to be realised that gifts without some inspection, mere liberality without careful examination of the objects to which it was directed, was not in itself a benefit. Appeal must be made to the pockets of the working classes themselves. In Liverpool, Northampton, Coventry, Manchester, Derby, and other large towns there were already large and self-supporting provident institutions.

Dr. ACLAND, President of the Medical Council, said that he paid great attention to this subject no less than thirty years ago, when he wrote a paper upon it, which even now he believed he should have very little to add to, and perhaps nothing to take away from. Being a hospital physician, he saw at once what the evil was, but in the old institutions there was a positive unwillingness to remedy it. The hospital system of Great Britain began about a century and a half ago, and became pretty general throughout the country. It was entirely a voluntary effort, and Montalembert mentioned it in one of his works as one of the greatest honours of England. But a class of practitioners sprang up who, being supported by the rates, were in charge of the poor and necessitous sick, and no distinction was drawn between those and the working classes who were able and willing to pay. The means of settling this was a union between the hospitals and the dispensaries. He tried that some years ago at Oxford, but failed, as the authorities there would not listen to his scheme; but Dr. Darbyshire, the great boating man, who succeeded him in the hospital, worked a portion of the town as a dispenser. One of the principles which should be acted on in London was the establishment of a system connecting the dispensary officers with a hospital. They would then visit the poor at their own homes, and send to the hospital only fitting cases. He formerly tried to get students to visit the poor, as was done in Edinburgh, but was not very successful.

Mr. MACKENZIE CHALMERS, of the London Fever Hospital, said that that hospital became a wholly paying institution about two years ago. The charge was three guineas for the whole time the patient remained there, which on an average was forty-three days, the actual cost of the hospital being about £9 10*s*. If an application was made for a remission or reduction of the fees, the committee investigated the case, and in many instances, such as those of daily governesses, the applications were granted. Subscribers of one guinea a year had the right to send a servant to the hospital, and arrangements were also made with clubs and hotels. There was also a ward in which the patients paid their full cost; that gave them an interest in the institution, and at the present time the committee was to a great extent composed of old patients. If the system of pay wards could be extended to general hospitals, it would be a great advantage to the public.

Mr. RADLEY, of the Metropolitan Provident Association, said that even if some of the liberality of the wealthy were diverted to the establishment of provident dispensaries instead of to the general hospitals, it was quite possible that the poor would be more benefited by it, as it would encourage habits of independence instead of fostering pauperism.

Mr. THOMAS RYAN, Queen Charlotte's Hospital, said that that institution had for one hundred and thirty years worked on the free system, but they were now contemplating payments by patients according to their means. Recently they had asked the patients whether they were ready to pay, and they found that they were generally very willing to do so. For three months the system was tried, and four-fifths of the in-patients paid on an average 10*s*. each, while one-half of the out-patients, who were very poor people, paid on an average 1*s*. 4*d*. each.

Mr. BOUSFIELD thought the committees of management would not feel themselves in a position to very materially restrict the number of out-patients until there was a network of provident dispensaries all over London connected with the hospitals.

A vote of thanks to the Chairman terminated the day's proceedings.

The Conference reassembled on Wednesday under the presidency of Mr. F. S. Powell.

A paper was read on the "Financial Difficulties of the Metropolitan Hospitals," by Mr. H. C. BURDETT. The author referred at some length to the unsatisfactory mode in which hospital accounts are often kept, and said he hoped that one of the results of the Conference would be an agreement as to the best and completest system of accounts. Particulars were then given of the increasing deficiency of income as compared with an enlarging expenditure and increasing work at the London hospitals, and suggestions were made as to the remedies to be applied. Too little attention, it was urged, was given to the necessity for adopting a regular system of raising voluntary income. In 1881 the metropolitan general hospitals only received 42·3 per cent. of their whole income from voluntary sources. The author hoped that the managers of more than one of the larger hospitals would dispose of the valuable sites on which the buildings were situated within an area of one mile and a half from Charing-cross, and remove the institutions to densely populated neighbourhoods where they were required. Each general hospital should map out for itself a district to which it should definitely appeal for support. Lastly, Mr. Burdett recommended the appointment of a Royal Commission to inquire into and report on the subject.

Mr. BOUSFIELD alluded to the functions assumed by Poor-law infirmaries, which, he said, were similar to those of hospitals embracing the same class of patients, and expressed an opinion that the charitable public would refuse to support both classes of institutions. The question of funds, he said, was greatly complicated by the existence of medical schools, which also interfered to a certain extent with the localisation of hospitals. He recommended a division of the expenditure with reference to the school and that relating to the hospital, and suggested that instead of drawing from the hospital funds for the support of the school, payment might be made by the State for each student trained in a hospital. With reference to the question of localisation, he said there was a great deal of caprice manifested by patients in their selection of hospitals.

Mr. CROSS, of the London Homœopathic Hospital, after criticising some of Mr. Burdett's statistics, said he considered that the most valuable part of the paper was that in which Mr. Burdett pointed out that it was a very serious mistake to imagine that to decrease the number of patients would reduce the expenditure to any great extent, for the salaries, wages, and nursing went on all the same.

Dr. TIBBITTS, of Bradford, contended that all hospital patients, except the very poorest, should contribute to the cost of their treatment. He then referred to certain evils connected with provident dispensaries. In some cases, he said, a large number of members applied for relief not because they wanted it, but simply because they were members. Amongst the members, too, were persons who had been in the habit of paying £5 or £10 a year for medical attendance, and who were receiving treatment at the dispensary for a mere pittance or 4*s*. 4*d*. a year. At the Bradford Infirmary the secretary was instructed to inquire carefully but courteously into the financial position of the patients, and the result had been that in the course of the year some hundred patients had been discharged as unfit inmates of the institution.

Mr. BURDETT, in reply, said he thought that Mr. Bousfield had somewhat misapprehended the work of Poor-law infirmaries, and the position which they occupied in the public mind. They were for paupers. As to buildings, they were probably even more complete than the voluntary hospitals, but their patients were the refuse of the slums of the metropolis, and it would be nothing short of cruelty to compel the respectable poor to have no other hospital refuge than the Poor-law Infirmary. He did not consider that the medical schools would prevent the localisation of the metropolitan hospitals. There was a large and growing feeling in the profession that in order to train the students in the best possible way, it might ultimately become necessary to have a central school at which the professors should devote their whole time to the different subjects which they had to teach. At present there were no means for remunerating the pro-

fessors except the fees of students, and therefore they had to depend upon private practice for a portion of their income. He thought it would be an enormous advantage if the Council of the Hospital Sunday Fund would decide that the benefits of the fund should only be given to hospitals which kept their accounts according to a certain system.

A paper on "The Difference between the Systems for Raising Income and Controlling Expenditure at the Metropolitan and Provincial General and Special Hospitals," was then read by Mr. THOS. BLAIR, general manager, General Infirmary, Leeds. The paper stated that in provincial hospitals annual subscriptions were regarded as the most important source of income, while the authorities of the metropolitan hospitals relied more upon spasmodic efforts to obtain donations to relieve their pressing necessities. The provincial hospitals very rarely advertised for money, their plan being to employ a collector, who devoted the whole of his time to the work, and was remunerated by salary and a commission on sums exceeding a fixed amount. Considerable sums were received yearly from a miscellaneous source, such as proceeds of cricket and football matches, musical entertainments, &c. Friendly Societies also organised gatherings at which collections for the hospitals were made. In some mills and workshops the workpeople regularly left a halfpenny or a penny weekly for the hospitals, and in others they worked a quarter of a day overtime once a quarter for the same object. The following are some of the largest provincial hospitals, with the amounts contributed by the working classes last year:—Birmingham General, £1983; Birmingham (Queen's), £931; Bristol Royal, £893; Hull General, £874; Leeds General, £3308; Leicester, £1599; Edinburgh Royal, £745; Glasgow Royal, £5352; Glasgow Western, £2735. The London Hospital, which boasts of having the largest number of beds in Great Britain, received only £1882, the collection of which cost £203.

Another paper on the same topic was read by Mr. R. HORDLEY, Secretary and House Steward, North Staffordshire Infirmary. It recommended that a record should be kept of the "accident" and "urgent" cases admitted as in- or out-patients, so that when they came from the establishments or workshops of non-subscribers, application might be made for subscriptions or for Hospital Saturday contributions. To control effectively the expenditure in an infirmary or hospital it was absolutely necessary that the managers should have a regular and detailed statement every month of the cost per head per day; so that any increase could at once be ascertained and explanations requested.

Mr. ROWLAND HAMILTON, while not disparaging professional accountants, said it was quite beyond their powers to give such a statement as should be really useful for the working of such an undertaking as a hospital, where the means had to be adjusted to the end from day to day or week to week. With regard to endowments, he considered that they should not be tied down to localities.

Sir WM. WHEELHOUSE said he was quite satisfied that there was not sufficient examination of the pecuniary means of those who took advantage of public hospitals. Neither was sufficient control always exercised over the daily expenditure. Fortnightly or monthly audits would remedy this.

Mr. LLOYD advocated management by a large board, including all the honorary officers. He did not think much of the crowding of hospitals in particular localities; for patients would always travel long distances in order to see the most eminent men, who were generally to be found in the larger hospitals. The difficulties of London hospitals had not arisen from local self-government, but rather from its absence. They were managed autocratically.

Mr. BLAIR agreed with Mr. Hordley that it was very desirable to have monthly returns of the cost of the in-patients. At the Leeds Infirmary if a well-dressed patient came in he was required to fill up a form with particulars as to his occupation and income. The same system was carried out with regard to surgical appliances. Last year nearly 300 people were sent away from the out-patient room as being in a position to obtain private medical advice, and as the result of a proper system of weeding out trivial cases nearly 3000 were sent away as not really ailing at all. Only twenty new cases per day were admitted to the out-patient department for treatment by the surgeons, and the same number for treatment by the physicians. In some hospitals the drug bill was far too large. His custom was to send out quarterly a list of the drugs required to different makers, and the difference in the prices asked was most amazing. The Leeds Infirmary passed through over 20,000 patients a year, but the drug bill was not more than £600 a year.

A paper was then read on the "Relation of Convalescent Institutions to Hospitals," by Dr. B. J. MASSIAH, late medical officer to the Barnes' Convalescent Hospital, Cheadle, and physician to the Sick Children's Hospital, Pendlebury. The author urged the extreme need of convalescent institutions in connexion with hospitals, and suggested that every hospital having more than fifty beds should have its own convalescent institution. The existing supply of beds should be utilised before additions were made. A step in that direction had been taken by the Charity Organisation Society in renting beds at convalescent institutions and placing them at the disposal of certain hospitals. The paper concluded by describing the progress of convalescent institutions in Scotland.

A paper was read on the same subject by Mr. LEVESON E. SCARTH, honorary secretary to the Convalescent Committee of the Charity Organisation Society. To obviate the existing difficulties in connexion with the rush for convalescent beds during the summer months, the author recommended the plan of permanent beds reserved by prepayment either for the whole year or only for the summer, and kept exclusively for the use of cases sent by the hospital. Mr. Scarth explained the plans of the Charity Organisation Society, which, he said, aimed at so developing its convalescent work as to be enabled, by degrees, to take the entire charge of the convalescent needs of all the out-patients from the London hospitals.

Sir RUTHERFORD ALCOCK read a paper "On the Necessity for a Royal Commission of Inquiry." It stated that if the large endowments and vast annual income contributed to the maintenance of public hospitals in the metropolis were to be so managed as to form any adequate provision for the sick, there must be great changes and reforms, not only in administration but in the location of the hospitals. The insolvent and bankrupt state of nearly all the London hospitals dependent on voluntary contributions was an increasing evil; while, on the other hand, the three great endowed hospitals, St. Bartholomew's, Guy's, and St. Thomas's, had a capital amounting to millions, none of which was available for other institutions. A Royal Commission of Inquiry was therefore necessary. The present system was converted into a means of pauperising the working classes, as well as small shopkeepers and tradesmen. The first step towards the removal of this abuse would be to have paying wards, and the principle of payment should also be extended to the out-patients. The distribution of the hospitals was anomalous. While ten of the principal general hospitals were grouped within a mile and a half of Charing-cross, giving 3439 beds, the whole of the north, east, and west of the wide area of 122 square miles, with a population of millions, had only five hospitals, affording 33 beds in the north, 810 in the east, and 232 in the west. Ancient usage afforded a precedent for two of the means of support for the London hospitals failing endowments or other sources—the reappropriation of funds already existing in endowments for poor or charitable purposes, and the levy of a poor or hospital rate in the districts surrounding such hospitals.

Mr. H. NELSON HARDY followed with a paper on the same subject. The reasons advanced for the appointment of a Royal Commission of Inquiry into the hospital system were: (1) The largeness of the interests involved, and the corresponding magnitude of the evils of defective hospital administration; (2) the wide difference of opinion which exists, even among those best acquainted with the facts, as to the nature and extent of the reforms needed; (3) the lack of information in official circles as to even the most elementary facts connected with hospitals; (4) the independence of the great endowed hospitals, alike of public opinion and of Government control, and the ascertained impossibility of gaining a hearing from the only public body which even indirectly controls them—the Court of Aldermen—for the most temperate statement of objections to the present mode of working those hospitals; (5) the arbitrary abuse of power exercised by the governing bodies of hospitals against any members of their medical staffs who have exposed the abuses of the present system, or tried to remedy them, while holding appointments at hospitals; (6) the futility of all efforts hitherto made to reform even the grossest abuses.

Mr. MORRIS, of St. Mary's Hospital, considered that the big metropolitan hospitals were at the present moment being slowly starved to death by the existence of a large number

of irresponsible special hospitals, and it would be a lamentable day for London if the large general hospitals were allowed to die out, and small special hospitals took their place. He would ask that the Royal Commission should inquire not only into hospital management and finance, but also into the whole question of the treatment of the poor.

Sir THOS. ACLAND, M.P., said if a public inquiry ever took place into medical schools, and if the mass of the people had their attention drawn to the relation between the curing of disease and the education of medical men it would be fortunate if there was not a great row. At Guy's an experiment was about to be tried in the direction of charging out-patients a small sum for medicine after their first visit. His opinion was that medical men were oppressed by the journals, and were not free agents. Some of them could be absolutely independent, but journalism had a great deal to answer for in these matters.

Mr. BURDETT was of opinion that without the aid of the Press it would be almost impossible for unendowed hospitals to live. The best managed institutions at the present time were powerless to let the public know how well they were managed, and which were the unworthy charities that they ought not to support. He asked for a Royal Commission in defence of the well-conducted hospitals.

The CHAIRMAN said it had been a great satisfaction to him to find an almost universal consensus of opinion adverse to the management of hospitals by guinea governors, and he hoped the time would soon come when the monstrous absurdity of management of charities by voters would cease to exist. It was necessary that the medical staff should either have a seat on all the boards, or an absolute right to express their views before the boards. With regard to the finances, the contrast between the active energy and liberality of the working men in the north, and the miserable apathy and dependence of those in London, was no credit to the metropolis. With respect to paying patients, he never could see why sick and benefit clubs should not in some way or other be intimately associated with the local hospitals. Medical schools were great national institutions, as important to the nation as the universities. No doubt they created some inconvenience, but the presence of students was a great advantage to a hospital. He congratulated the Conference on the entire absence of ill-feeling; not one word of objection had been uttered to the appointment of a Royal Commission even by those who were on the councils of hospitals, and he therefore thought it must be taken for granted that the managing bodies were no longer averse to such a commission. In conclusion, he thanked the writers of the papers for their valuable contributions.

Dr. GILBART SMITH moved, and Dr. SEATON seconded, a resolution, which was agreed to, appointing a committee to consider what steps should be taken to secure combined action among hospitals, and to decide as to future conferences.

A unanimous vote of thanks to the Chairman concluded the Conference.

DISTRIBUTION OF PRIZES BY LORD WOLSELEY.

THE prizes and certificates gained by the students of the Medical School, Charing-cross Hospital, were presented on Thursday afternoon by General Lord Wolseley in the lecture theatre, which was crowded by a large number of ladies and gentlemen. At the conclusion of the ceremony,

Lord WOLSELEY, after expressing the pleasure which he felt in being brought in contact with the number of young men beginning their career in life, said it had been his good fortune to be brought a great deal in contact with the noble profession to which they belonged, more especially with that branch of the profession belonging to the army. He had had a great deal to do with them, and they had had a great deal to do with him. (Laughter.) Like most men who had been in the army any length of time, he had had his share of knocks and blows, and he therefore owed a great deal to the medical profession. Looking back over a number of years and a number of campaigns, he could confidently say that he had never been brought into contact with any body of men in any department of the army who had done their duty with greater devotion to the service and to humanity than the medical officers of the army. In a paper that had been put in his hands with reference to volunteer medical organisation he observed a statement to the effect that at no battle-field since the world began were the wounded so promptly and efficiently removed as at the battle of Tel-el-Kebir. He could thoroughly bear out the truth of that statement, for he was not aware of any previous occasion upon which the wounded after an engagement had been better looked after or more quickly removed than they were after that battle. No doubt there were failures in all departments—amongst the doctors, and plenty among the generals, he was sorry to say. He would not venture to say that every medical officer in every war was perfection; but looking at them as a body, he believed that no men ever did their work better, especially during the recent war. He was aware that in the medical branch of the army there were changes and reforms required, but that was the case in every department; changes were constantly required if the army was to be kept in an efficient condition. The medical department was no exception to the rule. What could be more ridiculous than to attempt to carry on the medical affairs in the army on the same system as during the Peninsular war, or even the Crimean war. Every branch of science and every invention in scientific arrangements reacted upon the army, and there was no department in which invention and discovery reacted more forcibly than they did upon the medical department. But that was no reason why fault should be found with the medical officers. He had never done so himself, and he had never seen any reason to do so during his long career, for he always thought that they were thoroughly and zealously anxious to carry out their duties. Lord Wolseley then expressed the pleasure he felt in inspecting the ambulance drill of the students in Barrack-square. It was, he said, remarkably well done, and he hoped that the example set by the school would be followed by others throughout the country. He thought it would be very desirable that civil surgeons should be able to perform military duties on an emergency, and he hoped there would be a volunteer medical corps formed in connexion with every medical school.

A vote of thanks to Lord Wolseley brought the proceedings to a close.

Public Health and Poor Law.

LOCAL GOVERNMENT DEPARTMENT.

REPORTS OF MEDICAL OFFICERS OF HEALTH.

Epping Rural District.—This district has suffered somewhat severely from diphtheria, which during four separate outbreaks proved fatal in twenty cases. The disease was in all cases associated with sanitary defects. Sanitary progress is, however, being made; Epping, Harlow, and Buckhurst Hill have been provided with systems of sewers, a hospital for infectious diseases has been erected at Rood, houses are being provided with an adequate water service, as many as 110 certificates have been granted under the Public Health (Water) Act in respect of new houses, and a large number of nuisances have been dealt with either temporarily or by means of measures of permanent character; the whole of the work being under the supervision of Mr. T. Fowler, the medical officer of health.

Taunton Urban District.—The water-supply for the town of Taunton has long been in a most unsatisfactory condition, and hence we learn with satisfaction the near prospect of the conclusion of the public works now in progress. Notwithstanding the advice which has again and again been given to the authority both by their own officer, Dr. H. Alford, and others, the condition of sewers and their ventilation remain as bad as ever. Dr. Alford once more endeavours to press his advice in this matter, and he urges that in the face of the persistent outbreak of diphtheria with which Taunton has been visited there should be no further delay in providing

a remedy. Thirty-nine deaths occurred from this cause alone in a population of 16,611, and they tended materially to swell the general mortality, which was as high as 23·8 per 1000 living. Amongst the details which are referred to in connexion with the diphtheria outbreak is the occurrence of several attacks as the result of viewing the bodies of patients who had died of the disease. The infectious hospital continues to do much useful work. As many as seventy-nine patients were admitted into it during the year, and the value of the institution is gradually becoming more and more appreciated by the public.

Taunton Rural District.—Much has been done during the past year to improve the sanitary circumstances of this district, to which also Dr. Alford acts as medical officer of health. The population is nearly 20,000 and the death-rate has been about 17 per 1000. A number of drain nuisances have been effectually dealt with by sewerage and otherwise, and others are under consideration. The diphtheria, which affected the urban district, also caused 17 deaths in this district. It was originally imported from the urban district, and then, by means of mild cases, only recognised when the characteristic paralyses came on, it was in the main spread through the influence of the elementary schools.

Ramsgate (Urban).—It would be fortunate if the medical officers of health of all watering-places and health resorts could, at the opening of the approaching holiday season, present as clean a bill of health as that indicated by a monthly report furnished to his sanitary authority by the medical officer of health of the urban sanitary district of Ramsgate, Mr. Edward Walford. It appears that during the five weeks ending 23rd ult., only 20 deaths were registered within this sanitary district, which is calculated to be equal to an annual rate of 8·5 per 1000 of the estimated population. Beyond this low death-rate, which for so short a period as five weeks, in so small a population, is a fact of but little statistical value, it is still more satisfactory to learn that no death was referred to any of the principal zymotic diseases, and that no case of infectious disease occurred within the knowledge of the medical officer of health during the five weeks under notice, although a system of notification of such diseases, as efficient as any voluntary system can be, appears to be in satisfactory operation. With a similar reservation as to the value of the small basis of facts under observation, it may be noted that 7 of the 20 death were of children under five years of age, and that the annual birth-rate during the period of five weeks was equal to 32·9 per 1000.

Belfast.—During the four weeks ending the 26th ult. the births registered amounted to 659, and the deaths to 645, or 31 per 1000 of the population. The deaths included 120 cases of phthisis, and 152 of diseases of the respiratory organs, or a total of 272 from affections of the lungs. The death-rate from zymotic disease was not so high as in the previous month: scarlet fever (35 deaths), whooping-cough (29), and diarrhœa (19), being the principal causes of the mortality; while the deaths from the other contagious diseases were very few. Four deaths from small-pox were registered during the month.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

In twenty-eight of the largest English towns, 5657 births and 3191 deaths were registered during the week ending the 30th ult. The annual death-rate in these towns, which had exceeded 18·7 per 1000 in the two preceding weeks, rose last week to 19·3. During the thirteen weeks ending last Saturday the death-rate in these towns averaged 21·6, against 20·5 and 20·9 in the corresponding periods of 1881 and 1882. The lowest rates in these towns last week were 13·5 both in Portsmouth and Birkenhead, 13·6 in Brighton, and 14·2 in Bristol. The rates ranged upwards in the other towns to 24·0 in Huddersfield, 26·5 in Newcastle-upon-Tyne, and 27·1 in Manchester. The deaths referred to the principal zymotic diseases in the twenty-eight towns were 468, and exceeded the number returned in any previous week of the year, mainly owing to the increased fatality of diarrhœa; 129 resulted from measles, 124 from diarrhœa, 84 from scarlet fever, 60 from whooping-cough, 41 from "fever" (principally enteric), 22 from diphtheria, and 8 from small-pox. No death from any of these zymotic diseases was recorded either in Derby or in Halifax, whereas they caused the highest death-rates in Newcastle-upon-Tyne and Sheffield. Measles was proportionally most fatal in Liverpool and Newcastle-upon-Tyne; scarlet fever in Leeds and Sheffield; "fever" in Bolton and Portsmouth; and diarrhœa in Bradford and Bolton. The 22 deaths from diphtheria in the twenty-eight towns included 15 in London. Small-pox caused 4 deaths in London, 2 in Birmingham, and 1 each in Manchester and Newcastle-upon-Tyne. The number of small-pox patients in the metropolitan asylum hospitals, which had been 66 and 67 on the two preceding Saturdays, was 65 last week; 11 new cases of small-pox were admitted to these hospitals during the week, against 7 and 14 in the two preceding weeks. The Highgate Small-pox Hospital contained 9 patients on Saturday last, 1 new case having been admitted during the week. The deaths referred to diseases of the respiratory organs in London, which had steadily declined in the seven preceding weeks from 402 to 200, rose last week to 226, and exceeded the corrected weekly average by 17. The causes of 66, or 2·1 per cent., of the deaths in the twenty-eight towns last week were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in Brighton, Portsmouth, Bolton, and in four other smaller towns. The proportions of uncertified deaths were largest in Salford, Preston, Huddersfield, and Halifax.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had been equal to 24·5 and 25·3 per 1000 in the two preceding weeks, declined to 24·2 in the week ending the 30th ult.; this rate exceeded, however, by no less than 4·9 the mean rate last week in the twenty-eight English towns. The rates in the Scotch towns ranged from 16·8 and 18·6 in Leith and Aberdeen, to 28·2 in Glasgow and 30·5 in Greenock. The deaths in the eight towns included 95 which were referred to the principal zymotic diseases, showing a further considerable decline from recent weekly numbers; 41 resulted from measles, 26 from whooping-cough, 11 from diarrhœa, 6 from scarlet fever, 6 from "fever," 5 from diphtheria, and not one from small-pox. The fatal cases of measles, which had been 55 and 35 in the two preceding weeks, rose again to 41 last week, of which 30 occurred in Glasgow, 6 in Edinburgh, and 5 in Greenock. The 26 deaths from whooping-cough were 6 fewer than the number in the previous week, 10 being recorded in Glasgow, and 4 each in Dundee, Aberdeen, and Greenock. All the 6 fatal cases of scarlet fever, 3 of the 5 of diphtheria, and 4 of the 6 of "fever" were registered in Glasgow. The 11 deaths attributed to diarrhœa were considerably below the average for the season. The 87 deaths referred to acute diseases of the respiratory organs in the eight towns showed a further decline from recent weekly numbers, and were 10 below the number in the corresponding week of last year. The causes of 91, or nearly 16 per cent., of the deaths in the eight towns last week were not certified.

HEALTH OF DUBLIN.

The rate of mortality in Dublin, which had been equal to 23·4 and 25·2 per 1000 in the two preceding weeks, further rose to 26·1 in the week ending the 30th ult. During the thirteen weeks ending last Saturday, the death-rate in the city averaged no less than 31·1 (against 35·2 in the first quarter of the year), whereas the mean rate in the same period did not exceed 20·5 in London and 19·6 in Edinburgh. The 175 deaths in Dublin last week showed a further increase of 6 upon the numbers returned in the two preceding weeks; they included 7 which were referred to "fever," 5 to whooping-cough, 1 each to measles, scarlet fever, and diarrhœa, and not one either to small-pox or diphtheria. Thus 15 deaths resulted from these principal zymotic diseases, against 14 and 12 in the two previous weeks; they were equal to an annual rate of 2·2 per 1000, the rate from the same diseases being 3·2 in London and 2·2 in Edinburgh. The deaths referred to "fever," which had been 5 and 4 in the two previous weeks, rose to 7 last week, and were equal to a rate considerably exceeding that which prevailed in the twenty-eight English towns. The 5 deaths from whooping-cough showed a decline from recent weekly numbers. The deaths of infants and of elderly persons showed a considerable increase upon recent weekly numbers. The causes of 34, or 19 per cent., of the deaths registered were not certified.

THE SERVICES.

Surgeon-Major H. De Tatham, M.D., M.R.C.P. Lond., of the Bombay Army, has been appointed to officiate as Civil Surgeon at Ahmednagar.

ADMIRALTY.—The following appointments have been made:—Surgeon James Thomas William S. Kellard, to Bermuda Hospital, vice Henry Thompson Cox; Surgeon George, to the *Ganges*, vice James T. W. S. Kellard.

Correspondence.

"Audi alteram partem."

NOTIFICATION OF INFECTIOUS DISEASE IN EDINBURGH.

To the Editor of THE LANCET.

SIR,—In reply to my objection that his published figures show an increase in the number of cases of infectious diseases in Edinburgh, Dr. Littlejohn says that, "Dr. Carter stands alone among medical officers of health in protesting against the notification of infectious diseases." Even if this reply were correct, it could scarcely be considered relevant. It is, however, incorrect, as I have always advocated notification, my objection being to the creation of a new offence for medical men, and to their complete subordination to medical officers of health in a way which, as experience has shown, may cause them very great annoyance and harm; and, further, not a few medical officers of health have publicly expressed their concurrence with me in this objection. The serious question to consider is, "What system will most check the spread of infectious diseases?" That the early notification of such diseases, according to the Edinburgh plan, does not cause their early diminution, much less their cessation, the figures of Dr. Littlejohn conclusively prove. That gentleman now expresses his belief that "the continued low death-rate of Edinburgh, and especially the diminished percentage of zymotic mortality," are due to the Act. This is a distinct advance in the direction of definiteness. Hitherto he has not only demanded from ten to twenty years for his experiment before being able to decide on its value, but has also given large credit to auxiliary agencies, as specially tending, in his opinion, to promote its success in Edinburgh. The bases of his belief are these. The death-rate in Edinburgh has fallen from an average of 20·08 per 1000 for four years before the Act, to one of 19·41 for three years after it; and the zymotic mortality from 15·31 per cent. for ten years before, to 12·18 per cent. for three years after. Let us see what has taken place in England and Wales during nearly the same periods. For the five years 1876–80 the death-rate there was 20·8 per 1000 (itself a fall from 22, the average for the previous five years). During the next two years it was 19·25. But these figures show a much greater decline in this country without any Act than in Edinburgh with one, for if the fall in our mortality had been proportionate to that of Edinburgh it would only have reached 20·1 in the latter years, instead of 19·41. The questions, then, for Dr. Littlejohn to answer are—How does it happen that the decline in mortality in Edinburgh has lagged behind that for England and Wales, and why can he anticipate from the application of his Act here a success which he cannot, even under conditions specially favourable, attain there? Then, again, taking the fevers as typical of the zymotic diseases, influenced by sanitation, the decline in the country generally, without special Acts, has been very great. Thus, from 1870 to 1880 it was as follows:—1870, ·80 per 1000; 1871, ·70; 1872, ·61; 1873, ·58; 1874, ·59; 1875, ·55; 1876, ·44; 1877, ·42; 1879, ·30; 1880, ·32. Compare this with the fall in Edinburgh. But Dr. Littlejohn is surgeon to the police as well as medical officer of health, and in virtue of the former office he does two things. First, he insists on an official police inquiry in every case of death where there has been no medical aid, and thus indirectly compels people, even in trivial cases, to obtain such aid; and, secondly, he places a policeman at the door of any poor shopkeeper who wishes to retain his child at home, and thus indirectly compels removal to hospital without the form of legal compulsion. Dr. Littlejohn is my authority for these statements.

Lastly, it is incorrect to assume, as Dr. Littlejohn does, that there can be no medical opposition when none is expressed in the journals. None had been so expressed in the cases of Bolton, Blackburn, Warrington, and some other of the towns visited by the Liverpool deputation; yet inquiry on the spot elicited the fact that there was the greatest antagonism between many of the medical men of those towns and the sanitary authorities. No opportunity was given to the deputation to ascertain the state of opinion in Edinburgh, as the request sent to Dr. Littlejohn to invite medical men of both sides to meet them was not acceded to; and a medical man who did attend in order to give evidence informs me that he was told by Dr. Littlejohn "that the meeting with the gentlemen forming the deputation from Liverpool was strictly private," and on that account he was not admitted. I have confined myself to facts in the belief that the elucidation of this question will be thus better promoted than by sneer or innuendo, the exclusive use of which I willingly resign to Dr. Littlejohn.

I am, Sir, your obedient servant,

Liverpool, July 4th, 1883. WILLIAM CARTER.

MYXO-LIPOMATOUS TUMOUR.

To the Editor of THE LANCET.

SIR,—I was much interested in the case of myxo-lipomatous tumour given in THE LANCET of June 30th, by Dr. Wiglesworth, as in the year 1877 I lost one of my oldest friends from what I should think a precisely similar affection. My friend was himself a medical man, aged twenty-five; and I think it rather remarkable that the tumour should have grown to the size it attained without his being conscious of its presence, until during a trip into Wales, where he was assisting in a practice, he was suddenly attacked with colic, and the gentleman with whom he was staying detected a large mass of tumour in the lower part of the abdomen, and advised him to go at once to London and get the best advice about it. He accordingly did so, and I went with him to Mr. Christopher Heath, who very carefully examined him, and wished to have Mr. Erichsen's judgment on the case, which was at once obtained, the diagnosis of these distinguished surgeons being myxoma. Mr. Erichsen considered that the tumour had existed for a considerable time, and might have been congenital. The poor fellow lived for about three months after this, during which time he was attended by Dr. J. H. Galton, Surgeon-Major Orton, of the Guards, and myself. The mass gradually increased in size, and was aspirated, but only a little fluid containing spindle-shaped cells came away. Mr. Heath saw him again shortly before death, which happened on August 21st, 1877.

By his own particular request the abdomen was opened, and about 300 amber-like masses floating in a gelatinous fluid, adherent to and pressing on the intestinal tube, were extracted, weighing about 16 lb., but apparently there was quite as much left behind, which could not be got at and removed without disfigurement. I took the tumour, or rather all we could get away, to Mr. Marcus Beck, who pronounced it to be a myxoma with traces of degenerated cartilage mixed with it. I believe there are some portions of it preserved in the museum of University College. I do not think that in this case any operation could have saved the patient, as the abdominal and pelvic organs and the mass were all welded together.—Yours truly,

Penge, S.E., July 2nd, 1883. WILLIAM D. STRANG.

THE HOME SECRETARY AND DR. CORBETT BLADES.

WE think it due to Dr. Blades to publish the following letters:—

To the Right Hon. Sir W. V. Harcourt.

Re SANSOM, Deceased.

171, Kennington-park-road, London, May 11th, 1883.

SIR,—I have now fully considered what took place at the interview which you did me the honour to accord me on the 25th ult. You then informed me that you had decided, unless I resigned, to dismiss me from the position of

divisional surgeon of police, which I have now held without complaint for more than eighteen years, and you stated as the ground of your decision that I could not have treated Robert Sansom worse than I did in his last illness "if he had been a brute beast." You were good enough to tell me your two reasons for making this charge against me. The first was, that on the day preceding his death I ordered Sansom medicine and did not see that he had it. It is true that I then told Sansom to send for medicine, but at the time I did so I was not able to tell what was the matter with him, and the only medicine I could have given him would have been of the description known in the profession as a *placebo*—that is, medicine intended to please a patient while you watch for his symptoms to develop, and not intended to benefit him in any other way. I knew that the medicine could do him no real good; and I respectfully submit that with this knowledge I could not reasonably be expected to depart from the ordinary course of leaving the police to send for their medicine or to take special care to see that Sansom had the medicine. In a previous letter I have stated that the invariable practice is for the police to send for their own medicine. This statement of mine has been distinctly confirmed by the police officers.

Your second reason was, that I did not personally go to the hospital with Sansom, or send any written statement of his case to the hospital authorities, and you added that they had complained of this. The first part of this reason is also true, but the latter part is incorrect; and you appear to have overlooked two important facts:—1. I sent a verbal message by a superior officer, which message was duly delivered to the house physician of the hospital, and was to the effect that the case was urgent and obscure, and that the man appeared to me (to be suffering (as the post-mortem afterwards proved he was) from congestion of the brain. If I had gone personally or sent a written statement with him I could have given the hospital doctors no further information, while the man's removal might, if I had gone with him, have been delayed while I had to be in attendance on other patients. 2. The house physician of the hospital stated on oath, at the inquest, that if he had had any further statement from me he should have paid no attention to it, that he had never but once had a written statement from a divisional surgeon, and that the cases brought into hospital were usually like this, urgent in their nature, and had to be dealt with as they were, irrespective of the opinions formed upon them by previous medical attendants. Dr. Bristowe, the senior physician, and the only one besides the house physician who attended to the case, has himself informed me that he never made any complaint in respect of having no written communication from me about Sansom. It is incorrect, therefore, to suppose that the hospital authorities, by whom must be meant the doctors who had to deal with the case, have ever complained because I sent them no note of the case, and it is equally incorrect to suppose that I neglected either on the day before Sansom died or on the day of his death, to do any single thing which could, in my judgment, have conduced to his recovery or his comfort.

I have now dealt, as briefly as possible, with the two reasons which, as you were good enough to tell me, induced you to say that I had treated Sansom worse than a brute beast, and decided you to give me the choice between resignation and dismissal. I respectfully submit that these reasons do not justify either your statement or your decision. That I have incurred the enmity of some few members of the force by zealously discharging what I conceived to be my duty, and by preventing them from being placed upon the sick-list, without good cause, I freely admit; and it is obvious that these men have taken advantage of the death of Sansom, after an extraordinary and very obscure illness, to excite considerable prejudice in some other members of the force against me. This prejudice is now fast dying out; but it is no doubt simpler to dismiss a divisional surgeon, whatever his services may have been, than to brave the hostility of a section of the force, however small that section may be. I am confident that I have done my duty, and my conscience is free from any dereliction of duty, and I feel that my conduct does not justify me in resigning; but as an individual I am powerless against you, a Member of the Government. I must therefore leave you to act as you may think fit. At the same time I solemnly protest that in no way did I treat the deceased man Sansom "as a brute-beast," or otherwise than as a careful and humane doctor should treat a patient, and that I have never, by any act or omission in the discharge of my duties as divisional surgeon, deserved the censure you put upon me, or the injury which you, by the course you are adopting, must inflict upon a professional reputation built up by years of patient toil.

I am, Sir, your obedient servant,
C. CORBETT BLADES.

P.S.—I reserve to myself the right to publish this letter, and your answer, as I may see fit.

[COPY.]

Metropolitan Police Office, June 30th, 1883.

MY DEAR DR. BLADES,—I am sorry to inform you that I have received a letter from the Home Secretary stating that he has thought fit to dispense with your services as Divisional Surgeon, and that your pay is to cease from the 20th instant. I have accordingly made arrangements for nominating a successor at that period.

Believe me, yours very truly,
Dr. Blades. T. HOLMES.

SCOTTISH NOTES.

(*From our own Correspondent.*)

BEN NEVIS OBSERVATORY.

THE meteorologists who are anxious to provide a well-equipped institution for carrying on the work so pluckily commenced by Mr. Wragge have intimated the result of their appeal to the public for the necessary funds. So far a little over £3000 has been obtained, but the promoters deem £5000 a minimum. Mr. Wragge has found it impossible to give personal attention to the observations this year, but two gentlemen, trained under Mr. Wragge, have been appointed to the work, which will be more extended than heretofore. Simultaneous observations will be made at the summit of Ben Nevis and at the sea level, and the results will be wired to London and Edinburgh twice a day. Instruments will be placed at different heights on the mountain track, trained pigeons will be used in carrying messages, a well-made pathway to the top of the Ben is now being made, and permanent buildings for the convenience of observers and the protection of the instruments form part of the scheme. The full advantage of such an entirely new departure can hardly yet be anticipated, but enough is already known to encourage those best acquainted with the study, and to enlist the active sympathy of those who see in meteorological conditions an important influence in the causation of disease.

A MUSEUM OF HYGIENE FOR SCOTLAND.

The promising position of the Parkes Museum in London, and the increased attention everywhere felt, or at least expressed, with regard to all matters pertaining to the public health, have led to an opinion, which has been influentially stated, that Scotland should be provided with a collection illustrative of the state of sanitary science. It is needless to say that such a scheme would be enthusiastically received by the few active workers in the science of hygiene in Scotland, and by the many who know something of the subject; but the pecuniary difficulties would require very earnest effort for their removal. What is desiderated at present is some method of bringing the subject under the notice of those societies and individuals most likely to exert themselves in the matter, and it occurs to me that the forthcoming sanitary congress at Glasgow would be an eminently advantageous opportunity for its discussion. With sanitarians such as Professor Gairdner and Drs. Russell and Littlejohn taking a leading part in recommending the proposal, the public of Scotland would be readily interested; and these gentlemen have such prominent connexion with the work of the congress, that the subject would naturally fall to be considered by them. I believe, too, that Dr. Aubrey Husband has in former years invited public attention to the want of some such centre for sanitary teaching.

DUNDEE ROYAL INFIRMARY.

After the customary nine years of active work as a visiting surgeon to this institution, Dr. Campbell has been appointed

honorary consulting surgeon, and Dr. Steel Moon takes the vacant place on the staff.

ERRATUM.—A slight error in my notes a fortnight ago has been kindly pointed out. It is the medical officer to the parochial board at Galashiels, and not Dr. Murray, who attends at the poorhouse, upon whom the annoyance caused by a few over-zealous teetotallers has fallen.

PARIS.

(From our Paris Correspondent.)

THE COUNT DE CHAMBORD.

SINCE the accident that happened to the Count de Chambord at Goritz, and which was noticed in THE LANCET of May 26th, he has never recovered his former health and vigour. It will be remembered that notwithstanding the slightness of the injury that was then caused, the illustrious patient was obliged to lay up for some days. This confinement, though necessary at the time for the cure of the injury, acted prejudicially in another way; it increased the Count's obesity to such an extent that since his return to Frohsdorf, his permanent residence, he has been unable to take the active exercise to which he was accustomed. The obesity continued, in consequence, to increase, and he was advised to repair to Marienbad for a cure. He drank of the waters there, which are reputed to possess curative properties against this condition, for three weeks, when, on his return home, symptoms of disorder of the stomach appeared, and were attributed to the excessive use of those waters. This gastric derangement has quite puzzled the medical men in attendance, and those called in consultation from Vienna, the latter being Professors Billroth, Dratsche, Wieder, and Bamberger, who are far from being agreed as to the correct diagnosis. The condition of the patient is, however, considered very unfavourable, and what adds to the gravity of the prognosis is the discovery of fatty degeneration of the heart, an almost necessary complication of polysarcia. Telegrams reporting the condition of the Count reach Paris almost every hour, and the last up to this evening's mail describes the general state as being somewhat improved. The local symptoms, however, still cause great anxiety among the medical men, who have discovered an abscess in the stomach, to relieve which an operation is considered out of the question, owing to the low condition of the patient.

At Joinville-le-Pont, a suburb of Paris, recently, a young married couple, horticulturists by profession, were found dead in their greenhouse, where they had spent the night. The medical report stated that they were asphyxiated by the emanations from the flowers and plants.

M. Challemel-Lacour, the Minister for Foreign Affairs, has returned from Vichy, without, however, his health being much improved.

M. Charles Brun, the Navy Minister, whose health has also been very much shaken lately, is about leaving for the country for a few days' rest.

Paris, July 4th, 1883.

THE COLLEGE ELECTION.

AN exciting and keenly contested election to the Council of the Royal College of Surgeons took place on Thursday afternoon. The voting began at two P.M., and was continued till five. At the latter hour the doors were closed and the votes were counted, the result being as follows:—

Mr. COOPER FORSTER ...	181,	including	2 plumpers.
Mr. SYDNEY JONES	125	,,	21 ,,
Sir WM. MAC CORMAC ...	119	,,	8 ,,
Mr. Lawson...	98	,,	4 ,,
Mr. Durham	91	,,	0 ,,
Mr. Pemberton	88	,,	7 ,,
Mr. Harrison	81	,,	1 ,,
Mr. Macnamara	69	,,	2 ,,
Mr. Carter	61	,,	6 ,,

Mr. Cooper Forster was therefore duly re-elected, and Mr. Sydney Jones and Sir William MacCormac elected members of the Council. Nearly four hundred Fellows, of whom, it is said, an unusually large number were from the provinces, voted, but twelve votes were declared invalid in consequence of leaving more than three names unerased. On this, as on previous occasions, the various anatomical, pathological, and other specimens added to the Museum during the past year were exhibited in the Council room.

MEDICAL NOTES IN PARLIAMENT.

The Cholera in Egypt.

IN the House of Lords on Tuesday, Earl Granville, replying to the Earl of Wemyss, said there was not the slightest evidence that the cholera was brought by ships from India to Egypt. The Egyptian Government had displayed great energy in dealing with the infected districts, and the British General commanding had taken stringent precautions. Ten days' quarantine had been established at Cyprus, and twenty-one days at Malta and Gibraltar. The Order in Council which was first issued in 1873, inculcating the three principles of medical inspection, disinfection, and isolation, would be reissued with some essential alterations. He had received a letter from Sir William Gull expressing an opinion that the outbreak in Egypt was of a local character, and that an epidemic of cholera in Europe was not likely to follow.

The Public Health (Dairies, &c.) Bill passed through Committee, and was reported without amendments.

Irish Lunacy.

Lord Carlingford moved the second reading of the Lunatic Poor (Ireland) Bill, which requires boards of guardians to look after poor lunatics who may be at large, and on a magistrate's order to receive them into the workhouses. It also transfers the supervision and control of lunacy throughout the country to the Local Government Board. The scheme was adversely criticised by several noble lords, but the Bill was read a second time without a division.

In the House of Commons on Thursday, the 28th ult., a petition for alteration of the Medical Bill was presented from Glasgow.

The Contagious Diseases Acts.

Lord Hartington brought in the Government Bill, which was read a first time, for alteration of the Contagious Diseases Acts, in deference to the adoption by the House of Mr. Stansfeld's motion against the compulsory examination of women. The measure is described in the votes as a "Bill for extending to certain hospitals the provisions relating to workhouses which enable the detention therein of persons affected with diseases of an infectious or contagious character." Whilst deprecating discussion at this stage, the noble marquis candidly expressed his own regret that the experimental working of the Acts had not been developed, instead of being cut short by the vote of the House. After a brief protest by Mr. Puleston the Bill was read a first time.

On Friday, Sir W. Harcourt brought in his Local Government Board Bill for Scotland, which was read a first time, after an unfavourable criticism from several Scotch members.

On Monday, on the motion of Lord R. Churchill, a return was ordered of the number and salaries of coroners in England and Wales. Mr. Gladstone, in reply to Mr. Broadhurst, declined to advise the appointment of a Royal Commission to inquire into the subject of dwelling accommodation for the working classes. Mr. Samuel Smith gave notice that on the Education Estimates he will call attention to the overstrain of both pupils and teachers under our present system of primary instruction.

The Indian Medical Service.

Mr. Gibson asked the Under-Secretary of State for India whether there is not great stagnation of promotion, and consequent dissatisfaction, in the Indian Medical Service; whether this stagnation is owing to the abolition of a number of higher grade appointments, and also to the disbandment of a number of native regiments; whether the prospects of promotion to the rank of Deputy Surgeon-General of several

Brigade Surgeons and Surgeons Major in the Indian Medical Service have been destroyed by recent alterations and arrangements which did not exist when the officers affected joined the service; whether the Government will consider the propriety of granting increased pensions to such Brigade Surgeons and Surgeons Major as compensation for their altered prospects, and as inducements to retire and make vacancies for the surgeons on the establishment who are now unemployed; whether the difference between the rates of pay drawn by Brigade Surgeons and Surgeons Major and the rates of pay that would be drawn by junior officers for the same duties would more than compensate Government for the increased expenditure that would have to be incurred to induce senior officers to retire; and whether the Government have any scheme ready to meet the grievances of the Indian Medical Service.—Mr. Cross said promotion in executive branches was governed solely by length of service. There had been a considerable reduction in the number of appointments to the Indian Medical Service during the past and present year, and this would shortly remove the differences that had previously existed through the disproportion in the number of these officers as compared to others. In this expectation it was not considered expedient to have recourse to higher rates of pension; it was, therefore, unnecessary to calculate what the financial effect of such a measure would be. The injury to the medical service, he assured the right hon. gentleman, was only nominal. The future of the medical service of India was now a subject of discussion at the War Office. The scheme for reorganising the department had no reference to any grievance of the Indian Medical Service.

The Cholera in Egypt.

Lord E. Fitzmaurice, in reply to some interrogatory remarks by Sir Stafford Northcote, said he had a telegram from Mr. Cookson at Alexandria, dated June 30th, stating that the number of deaths to date had been 109 at Damietta, 4 at Mansourah, and 4 at Damanourah; and another telegram, dated July 1st, giving the numbers as 140 at Damietta and 14 at Mansourah, and adding that there was no further despatch from Damanourah. The Egyptian Government had taken every precaution by establishing a sanitary cordon around the district which was the headquarters of this terrible disease; and as far as it was possible to judge as yet the disease had hardly made itself felt beyond that district. Although it was perhaps rash to speak of the matter so soon, it looked as if the measures which had already been taken had to a considerable extent succeeded in confining the disease within that district, and so far isolating it, because, although several days had now elapsed since the outbreak, the disease remained confined to the district where it broke out.

Dr. Lyons presented twenty-four petitions of licentiates in medicine of the King and Queen's College of Physicians in Ireland for alterations in the Medical Bill. A petition was presented from Nathaniel Cook "for protection from dissection."

Uncertified Deaths in Scotland.

Dr. Cameron gave the following notice for Monday next:—To ask the Lord Advocate whether his attention has been called to an article in THE LANCET of 23rd June, setting forth that, while the average proportion of uncertified deaths in the large towns of England is less than 2½ per cent., in Scotland, according to the returns of the Registrar-General, the proportion in the eight principal towns in 1881 and 1882 was nearly 20 per cent.; and whether it is true, as stated by THE LANCET, that the number of post-mortem examinations in cases of uncertified death is decreasing, in consequence of the stringency of the Exchequer in disallowing fees, and "that in many counties Procurators Fiscal declare that pressure is put upon them for the purpose of diminishing expenditure in this direction."

On Tuesday, the Medical Act (1858) Amendment Bill, which provides for the representation of the Royal University of Ireland on the Medical Council, was read a second time.

The German Vaccination Laws.

Dr. Cameron gave notice to ask the President of the Local Government Board whether his attention has been called to a statement in the *Königliche Privilegirte Berlinische Zeitung*, regarding certain tables recently issued by the German State Health Office, illustrating the working of the vaccination laws in Germany; and whether he will have the goodness to procure a copy of the tables for the library of the House.

Lord E. Fitzmaurice, in reply to Sir E. Watkin and Mr. Gourley, referring to the outbreak of cholera in Egypt, said it was not the intention of Her Majesty's Government at present to propose an international conference on quarantine regulations.

Mr. Trevelyan, in answer to Colonel King-Harman, said an opportunity for discussing the question of the case of harmless lunatics and idiots in Ireland would arise on the Lunacy Vote in Supply, and again on the Government Bill when it came down from the Lords.

Irish Workhouse Hospitals.

In reply to Mr. Moore, Mr. Trevelyan said it had been the practice since 1862 to receive into Irish workhouse hospitals paying patients suffering from infectious disease; and there were also powers of compulsory removal to these hospitals. These non-pauper patients were required to wear a simple hospital dress, having nothing in common with the workhouse dress, in order to prevent their spreading infection when they returned home; but in some cases, including members of the constabulary, the guardians had relaxed this rule and allowed the patients to wear their own garments. The Local Government Board regarded this relaxation of the rule as unavoidable; and he would not favour any modification of the rules in that direction.

Schools and Epidemics.

Mr. Mundella, replying to a question by Mr. Rankin as to the compulsory closing of elementary schools on account of epidemic disease, said although the period during which the school was so closed could not count towards making up the required number of weeks' attendance of children, it might be considered in awarding the Government grant, and the inspector might waive the examination of children who had been ill.

On Wednesday, a petition in favour of the Medical Bill was presented from Hertford.

Cholera in Salem.

On Thursday, Mr. O'Donnell asked the Under-Secretary of State for India whether he had heard that cholera in a severe form was reported by the editor of the Madras *Hindu* to have broken out in Salem; that the collector remained at a distance in a mountain sanatorium; and that the native municipality had been dissolved since the late riots; and if he could state what authorities were responsible for the care of public health in Salem.—Mr. Cross said he had not seen the *Hindu*, but the official returns which had been received up to May 23rd did not state that cholera existed in Salem. He had not been informed that the native municipality had been dissolved, but the collector was absent, and his *locum tenens* was responsible for the public health.—Mr. O'Donnell gave notice to put further questions as to the prevalence of cholera in India, and the neglect of Her Majesty's Government to inform the Egyptian Government of the fact.

Medical News.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.—The following gentleman was duly admitted a Fellow of the College on June 28th:—

Herbert Watney, M.D. Camb., Wilton-crescent.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following gentlemen passed the Primary Examination in Anatomy and Physiology at meetings of the Board of Examiners on Monday, Tuesday, and Wednesday last:—

E. C. Cameron and William D. Oakley, M'Gill College, Montreal; S. A. Erulkar and J. F. Mirza, Bombay; A. C. Purchas, J. E. Gemmell, and T. G. Churcher, Edinburgh; J. G. Adami and S. R. O. Dudfield, Cambridge; R. Pearson and Duncan M'B. Greig, University College; J. F. H. Edwards, Birmingham; H. Shackleton, Dublin; J. T. Winter, F. J. Brown, Ernest E. Bowden, Manchester; G. Griswold, New York; Evan Evans, St. Mary's Hospital; Arthur J. Briant, Albert E. Davis, Chas. L. Martin, and Benjamin Sumner, Liverpool; C. J. Glasson, Bristol; Richard M. Hay and John Barker, Newcastle-upon-Tyne; Frederic D. Bird, Melbourne; John Jeeves and Charles E. Baxter, Sheffield; H. H. Corbett, Thomas

S. Heaton, and Herbert Blackburn, Manchester; H. H. Crickett, St. George's Hospital; G. W. F. Paul, University College; B. C. Simpson and R. J. Burns, Newcastle-on-Tyne; James G. Laing, Liverpool; Joseph H. Collymore, Guy's Hospital; Wm. K. Clayton, Leeds; P. G. Meldrum, Toronto; Thomas Richards, Bristol.

UNIVERSITY OF OXFORD.—At a convocation held on June 14th the degree of M.B. was conferred on the following gentlemen:—

Sidney Davies and Joseph Baldwin Nias, Exeter; Charles Montague Chadwick, Oriel; Owen Clayton Jones, Queen's; Arthur Brstowe Carpenter, New; Alfred Jasper Anderson, Magdalen; Francis William Humphrey, Christ Church; Arthur Shadwell, Keble; Charles D'Auvergne Collings, Trinity.

UNIVERSITY OF DUBLIN.—The following degrees were conferred on the 29th ult.:—

BACHELOR IN SURGERY.—Edmund Francis Beveridge, Monckton O'Dell Braddell, George Cowen, Cecil Arthur Digby, Francis James Drury, Frederick Conway Dwyer, Charles Joseph Fagan, Charles Wolfe Hamilton, Thos. Wilfred Haughton, Hugh Falconer Oldham, Chas. Thos. Poland, John Harrison Scott, Henry Neville Thompson, A. Edward Wright.

BACHELOR IN MEDICINE.—Edmund Francis Beveridge, H. Edmund Blandford, Chas. Holcroft Blood, Monckton O'Dell Braddell, John James Cochrane, George Cowen, Cecil Arthur Digby, Geo. Magill Dobson, Francis James Drury, Frederick Conway Dwyer, Charles Joseph Fagan, William G. Fenton, Thomas Wilfred Haughton, Henry M'Quade, Hugh Falconer Oldham, Charles Thomas Poland, John Harrison Scott, Robt. Edw. Sproule, Henry Neville Thompson, A. Edward Wright.—Frederick John Driver (Cantab. *ad eundem gradum*).

MASTER IN SURGERY.—Isidore M'William Bourke, Ephraim MacDowell Cosgrave (*stip. cond.*), James Gloster.

LICENTIATE IN MEDICINE.—Green James Sullivan.

DOCTOR IN MEDICINE.—Isidore M'William Bourke, Robert Nickle Denning, Frederick John Driver, Edward Fawcett, John R. Kirkpatrick, Samuel R. Mason, Travers Robert Montgomery Smith, Montgomery A. Ward, Bertram Coghill Windle.

APOTHECARIES' HALL.—The following gentlemen passed the examination in the Science and Practice of Medicine, and received certificates to practise, on June 28th:—

Brown, William Henry, Parkhurst-road, Bexley, Kent.
Cox, John Henry, Doddington-grove, Kennington.
Hill, Thomas James Cooke, Bonython, Grampound, Cornwall.
Fletcher, Wilfred Wm. Ernest, Malvern Cottages, Thornhill-road.
Maling, William Haygarth, Sunderland.
Mills, Robert, Edward-street, Hampstead-road.
Scott, Bernard Charles, Derwent-road, Anerley.
Strugnell, Walter Thomas, Portadown-road, Maida-vale.

At the recent examination for the Prizes in Botany given annually to medical students by the Society, the successful candidates were—

1st.—Geo. Bernard Hoffmeister, St. Bartholomew's Hospital. A Gold Medal.
2nd.—Frederic Wm. Green, St. Bartholomew's Hospital. A Silver Medal and a Book.

THE Marquis of Salisbury distributed the prizes to the successful students at King's College on Tuesday last.

JOHN WRIGHT, Esq., M.D. Edinburgh, &c., has been gazetted a member of the Medical Board of the Cape Colony.

COOMBE LYING-IN HOSPITAL.—For the purpose of removing the debt on this hospital a bazaar was recently held in the Royal University Buildings. The result has been very satisfactory, a sum of upwards of £700 having been added to the funds of a most deserving charity.

PROPOSED HEALTH EXHIBITION IN MANCHESTER.—The exhibition recently held in London under the auspices of the National Health Society having been attended with great success, it is proposed to hold in Manchester in July, August, or September next a similar exhibition.

BRITISH HOSPITAL AT JERUSALEM.—A meeting was recently held at the Jerusalem Chamber, Westminster Abbey, in furtherance of the objects of the British Hospice and Ophthalmic Dispensary at Jerusalem, which is under the management of the Order of St. John of Jerusalem. The annual report stated that the average daily attendance was eighty, comprising the poor of all nationalities and religions. Donations to meet the current expenses were earnestly pleaded for by several speakers.

ST. JOHN AMBULANCE ASSOCIATION.—The Duke of Connaught on the 30th ult. distributed at the Guildhall certificates to members of the Metropolitan District of the Association. The successful candidates included more than fifty men of of the Fire Brigade and thirty-eight City police constables.

CITY PROVIDENT DISPENSARY.—At the sixth anniversary dinner recently held in connexion with this institution, it was stated that since its establishment in 1877 3560 surgical appliances have been supplied to deserving applicants. The subscriptions and donations announced during the evening amounted to nearly £200.

NORTH-WEST LONDON HOSPITAL.—The new wing of this hospital—to be called the Helena Wing—was opened on Tuesday by Princess Christian. This addition will raise the accommodation for in-patients from twenty-four beds to fifty, and its cost will be about £2000, towards which £1300 has been collected.

THE committee of the Manchester Hospital for Consumption and Diseases of the Chest are endeavouring to raise funds for the erection of a new building, the present one being found inadequate to meet the demands on its means of affording accommodation for poitrinaires in the district. A fund of £12,000 is thought to be needed for the above purpose.

IN order to secure the better conveyance to hospital of men who have been injured at the docks or elsewhere, the committee of the Liverpool Northern Hospital have decided to establish a horse ambulance service, which will be ready to proceed at a moment's notice fully equipped and with a medical attendant to the scene of any accident that may be reported.

COLONEL BOLTON reports the condition of the Thames water during May to have been good in quality from the 1st to the 11th of the month; it then became bad and remained so until the 17th, when it recovered its former purity. All the water companies "are now giving constant supply to some extent, and in some portion of their districts," under the provisions of the Metropolis Water Act, 1871.

THE Convalescent Home for Working Men established in connexion with the Hospital Saturday movement, though quite distinct from the fund, was formally opened on the 30th ult. by Mr. S. Morley, M.P. The institution is situated at St. Margaret's Bay, Dover, and provides accommodation for thirty male patients. The total receipts towards the project have been £3200, of which £2800 has been paid for the freehold and furniture of the home. Mr. Gordon Brown is the medical officer.

ON the 4th instant, the Duke and Duchess of Connaught paid a visit to St. Thomas's Hospital for the purpose of inspecting the various wards of that institution. Their Royal Highnesses were received at the central hall in Lambeth-road by Alderman Stone, the treasurer, and the medical staff, and were forthwith conducted through the wards. Upon taking his leave, the Duke expressed the pleasure it gave him and the Duchess to visit the institution, and highly complimented the authorities in charge on the manner in which it is conducted.

VOLUNTEER AMBULANCE INSPECTION.—The Ambulance detachment of the 2nd North Yorks Volunteers was inspected twice last week, when the regiment was under canvas at Ripon. On June 25th Major-General Cameron, commanding the Northern District, visited the camp, saw the detachment go through their stretcher drill, and expressed himself much gratified by the manner in which the men did their work. On June 29th Colonel Barrett, commanding the 19th Regimental District, officially inspected the battalion. The ambulance detachment marched past with the rest of the regiment, and were put through a series of movements by Surgeon-Major Taylor, before the inspecting officer. After Colonel Barrett had addressed a few words to the junior medical officers, Drs. W. T. Colby and R. Bruce Low, the certificates of proficiency were presented to those bearers who had not received them previously.

Medical Appointments.

Intimations for this column must be sent DIRECT *to the Office of* THE LANCET *before 9 o'clock on Thursday Morning at the latest.*

BAYNES, Mr. J., jun., has been reappointed Public Analyst for the Borough of Kingston-on-Hull.

BEATTIE, HENRY, L.R.C.P.Lond., M.R.C.S., has been appointed Assistant Medical Officer and Dispenser of Medicines, Mile-end Old Town Hamlet.

DUNN, THOMAS, M.B. & C.M., has been appointed Assistant Medical Officer to the Barony Parish Hospital, Glasgow, vice Dr. C. S. Young, resigned.

FEAR, WILLIAM, M.R.C.S., has been appointed Medical Officer for the Horsmonden District of the Tonbridge Union.

HAMILTON, ARCHIBALD A., M.B.Dub., has been appointed Medical Officer for the Epworth District of the Thorne Union.

HAULTAIN, F. W. N., M.B., C.M., has been appointed House-Surgeon to the Royal Maternity Hospital, Edinburgh, vice Atkinson, whose term of office has expired.

HEWETSON, H. BENDELACK, M.R.C.S., Surgeon to the Leeds Public Dispensary, has been appointed Honorary Surgeon to the Eye and Ear Department of the General Infirmary, Leeds, vice Robert P. Oglesby, deceased.

LAWFORD, J. BOWRING, M.R.C.S., L.R.C.P.Lond., has been appointed Registrar and Chloroformist to the Evelina Hospital for Children.

TAYLOR, H. E., M.R.C.S., L.S.A.Lond., has been appointed Assistant-Surgeon to the Eye and Ear Hospital, Bradford, Yorks.

THORP, SIDNEY, M.R.C.S., L.S.A.Lond., has been reappointed Medical Officer for the Second District of the Halstead Union.

WHITTINGDALE, J. F. S., M.B.Camb., has been appointed House-Surgeon to the Royal Maternity Hospital, Edinburgh, vice Thomson, whose term of office has expired.

Births, Marriages, and Deaths.

BIRTHS.

BRANFOOT.—On the 4th ult., at Madras, the wife of A. M. Branfoot, M.B., Surgeon, Indian Medical Department, of a daughter.

CLOUGH.—On the 29th ult., at Hambledon, Hants, the wife of M. E. Clough, of a daughter.

CROWE.—On the 25th ult., at Shaw-street, Worcester, the wife of G. Wyndham Crowe, M.D., of a son.

GABE.—On the 29th ult., at the London Dispensary, Church-street, Spitalfields, the wife of J. R. Gabe, M.R.C.S., of a daughter.

GOWERS.—On the 2nd inst., at Queen Anne-street, the wife of W. R. Gowers, M.D., F.R.C.P., of a daughter.

HARRIS.—On the 27th ult., at Dalston, Cumberland, the wife of Alfred Harris, M.B. & C.M., of a son (stillborn).

HUTTON.—On the 27th ult., at West-green-road, Tottenham, N., the wife of Edwin R. Hutton, L.R.C.P., of a son.

MEYERS.—On the 30th ult., at Woodstock-road, Finsbury-park, the wife of Herbert H. Meyers, L.R.C.P., M.R.C.S., of a daughter.

MILBURN.—On the 1st inst., at 43, Claremont-square, N., the wife of F. L. Milburn, M.R.C.S., of a son.

PIETTS.—On the 21st ult., at Wyndham House, Ryde, Isle of Wight, the wife of J. Monham Pietts, M.D., of a son.

THOMPSON.—On the 29th ult., at the City and County Asylum, Stapleton, near Bristol, the wife of George Thompson, M.D., Medical Superintendent, of a daughter.

MARRIAGES.

CHIPPERFIELD—READ.—On the 30th ult., at the Holy Trinity, Twickenham, by the Rev. David Anderson, M.A., Vicar, Thomas John Burgoyne Pearse Chipperfield, M.R.C.S., of Boxham, Oxon, eldest son of the late William Nathan Chipperfield, Esq., M.R.C.S., Surgeon, Indian Medical Service, Madras, to Katherine Elizabeth, only daughter of the late William Read, Esq., of Twickenham, Middlesex.

NEWTON—NEALE.—On the 3rd inst., at St. Barnabas Church, King-square, by the Rev. R. Heyliger, M.A., William Thomas Newton, M.R.C.S., L.S.A.Lond., to Laura Neale, both of King-square, E.C.

POTTS—WALKER.—On the 27th ult., at the Bank, Old Deer, Aberdeenshire, by the Rev. James Peter, assisted by the Rev. William Burgess, James Ashford Potts, M.B., M.R.C.S., eighth son of the late George Potts, Solicitor, of Broseley, Shropshire, to Mary Anne Gordon, eldest surviving daughter of John Walker, Esq., Bank Agent, Old Deer.

THOMAS—GREEN.—On the 27th ult., at the Parish Church, Bradford, Robert Henry Thomas, L.R.C.P., M.R.C.S., of Hollins House, Hebden Bridge, eldest son of the late Rev. Henry Thomas, of the same place, to Mary Hannah Ruth, daughter of the late William Green, of Hebden Bridge.

DEATHS.

CUPISS.—On the 30th ult., Francis P. Cupiss, M.R.C.S., of St. Servan, France, aged 56.

HARWOOD.—On the 4th May, at Sydney, New South Wales, Thomas Scutter Harwood, Surveyor, formerly of London, aged 72.

SCRIVEN.—On the 28th ult., at his residence, Frederick-place, Weymouth, Samuel Swain Scriven, M.D., aged 80.

N.B.—*A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.*

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET OFFICE, July 5th, 1883.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Dry Bulb.	Wet Bulb.	Solar Radia in Vacuo.	Max. Temp. Shade.	Min. Temp	Rain fall.	Remarks at 8.30 A.M.
June 29	30·04	S.	72	65	124	85	53	..	Bright
,, 30	29·99	S.	74	66	110	85	64	·22	Overcast
July 1	30·08	W.	63	59	119	79	55	..	Bright
,, 2	30·09	S.E.	70	62	123	85	59	..	Cloudy
,, 3	29·86	S.E.	71	66	119	79	64	·21	Overcast
,, 4	29·82	S.E.	60	57	96	67	53	·04	Raining
,, 5	29·89	S.W.	62	57	117	71	53	·06	Cloudy

Notes, Short Comments, and Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

All communications relating to the editorial business of the journal must be addressed "To the Editor."

Lectures, original articles, and reports should be written on one side only of the paper.

Letters, whether intended for publication or private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

We cannot prescribe, or recommend practitioners.

Local papers containing reports or news-paragraphs should be marked.

Letters relating to the publication, sale, and advertising departments of THE LANCET *to be addressed "To the Publisher."*

THE LIBRARY OF THE ROYAL COLLEGE OF SURGEONS.

A CORRESPONDENT calls our attention to the inconvenience occasioned by the restrictions placed upon the use of the College Library, rendering it practically valueless to members. Complaints as to this matter have been made before. The grievance is evidently widely felt, and should not, we think, be overlooked by the Council.

AN OBSCURE CASE.

To the Editor of THE LANCET.

SIR,—Will you kindly permit me to lay before yourself and your readers the following somewhat serious and unusual case?

The patient six months ago complained of swelling of the glands of the neck as far down as the submaxillary on both sides. There was no pain—or at least only occasionally—or tendency to suppuration all the time, but the glands continued to enlarge, and at present they are of an immense size, and the surrounding tissues and skin puffy, œdematous, and discoloured. I have had several consultations about him, and find that opinions differ. One calls it "lymphoma," another "acquired scrofula," and a third "scirrhous hardness." There are very little above the normal quantity of white corpuscles in the blood, if any, and the general health is fairly good. The pulse is generally close on 100, but the temperature is not very high.

If I have succeeded in making the case intelligible, I shall be very glad if you or any of your readers could inform me of any serviceable treatment, and acquaint me of their experience, and if "lymphoma" has ever been made stationary or cured.—I am, Sir, yours truly,

Ravenslea, Whalley Range, Manchester, A. SMEAL.
June 29th, 1883.

*** Are any other of the lymphatic glands of the body enlarged? Are there progressive anæmia and debility? Painting with a solution of iodoform and collodion (ten per cent.) night and morning might be tried, and iodine internally, combined with cod-liver oil or iodine, as indicated.—ED. L.

Dr. James Copland (Dunedin).—A note calling attention to the matter referred to by our correspondent appeared in THE LANCET of March 10th, p. 436.

Sufferer is referred to a general notice above.

APOMORPHIA.

To the Editor of THE LANCET.

SIR,—Will any of your readers kindly inform me as to the best method of dissolving apomorphia (the hydrochlorate of apomorphia). One in fifty is not soluble in cold water, and in hot water on cooling almost entirely crystallises out. I am, Sir, yours, &c.,

July 2nd, 1883. L.R.C.P. Lond.

YELLOW FEVER.

DR. DOMINIGOS FREIRE, appointed by the Brazilian Government to investigate the nature and cause of yellow fever outbreaks, has reported some of his researches. He has found in the soil of cemeteries where yellow fever subjects have been interred myriads of microbes identical with those seen in the vomit, blood, and urine of patients suffering from the fever, as well as vibriones in rapid motion. Dr. Freire believes that, after passing through the porosities of the earth, these germs disperse themselves in the atmosphere, whilst others are carried by storm rains to the towns, and there provoke epidemics of the disease. He proposes that the bodies of all persons who die of yellow fever be cremated.

A NEW FUNCTION FOR SILICA.

THE New York *Medical Record* is responsible for the following:—

"Dr. G. Kerlus argues from the facts of comparative physiology that fine sand is a good thing for dyspeptics to take with their food. Herbivorous animals all eat a little dirt with their regular food, and it makes it more 'porous.' Fowls and birds of all kinds also take sand with their meals. Why not therefore man? says Dr. Kerlus. Putting this brilliant piece of inductive reasoning into practice, he has administered finely ground sand with the food of his patients, and, of course, reports cures."

Mr. Cooper.—It is difficult to prevent a coroner making private remarks, but it is very wrong in a clerk to guardians to reproduce such, especially in the absence of the person injured by them.

"LAWN TENNIS LEG."

To the Editor of THE LANCET.

SIR,—Some cases of rupture of the pronator group of muscles having been recorded in your journal as due to the back stroke in lawn tennis, and termed "lawn tennis arm," I have thought it of sufficient interest to forward you a report of a case that has recently occurred in my practice, where rupture of the plantaris tendon took place during recreation at the same game. It is of more than passing interest, inasmuch as both the tendons gave way on separate occasions, and because no extreme tension can be said to have happened either time.

I was summoned to see J. C. C——, aged forty-one, an able-bodied, muscular, healthy Englishman, on Feb. 21st, 1883, who was said to have met with an accident while playing tennis in the Drill Hall (the ground at this time of the year being covered by about four feet of snow necessitates playing under cover). He told me that while reaching for a ball (not at all violently) he was seized with a sudden sharp pain in the left calf. It stung so that he turned round and asked who threw the ball at him. He then found he could not stand or bear any weight on that leg. He was lying on a couch when I reached him, and quite free from pain. I found the calf swollen and stiff, with a slight contraction of the gastrocnemius as if to steady the injured tendon. On deep pressure about the lower fourth of the belly of the gastrocnemius I could feel a small boggy swelling, and this pressure caused much pain. I was feeling the fractured tendon through the thick muscular layer which covered it. No doubt the plantaris tendon had snapped. I put the part at rest, and approximated the ends as well as possible by flexing the leg on the thigh and extending the tarsus. In this position, which he maintained during the healing process, no pain was experienced. In about four weeks he began to walk, though a little lame, and in a short time everything seemed as before. I gave him permission to play tennis again before the middle of May, cautioning him to begin quietly, and not to exert himself. This he did, and in a couple of weeks could play as vigorously as ever and as well, and suffered no pain whatever. On May 29th, after playing a whole two hours hard, he was walking across the ground to take the "serve," when he again felt something suddenly snap, and again made precisely the same remark to the bystanders, asking who struck him on the leg. On arriving I found exactly the same condition as before described, but in the other leg. I have him at present under the same treatment (rest), and I may say he is eagerly looking forward to having it united again, so that he may measure bats once more across the grassy sward. I am, Sir, yours, &c.,

Rideau-street, Ottawa, Canada. R. W. POWELL, M.D.

"THE LATE ST. PANCRAS VACCINATION CASES."

To the Editor of THE LANCET.

SIR,—It is due to myself that I should write to correct certain inaccuracies in your article of the 23rd ult., dealing with two cases of "alleged death after vaccination." Respecting "a second case of alleged death after vaccination," you say that "on March 11th a neighbouring practitioner was called in to see the child, and ordered it to have half a pint of milk daily." This statement is incorrect, as I gave instructions only as to the preparation of the milk, and advised that the milk should be obtained from Jones's Cumberland Dairy; consequently the child was not "underfed" with my sanction. Again, you say "from March 11th to May 13th, during nearly the whole of which period no medical advice was sought and no medical treatment adopted," whereas the child was prescribed for and seen by Mr. C. T. Maddison, L.S.A., 18, William-street, Regent's-park, N.W., Dr. James Edmunds, and the house-surgeon at the London Temperance Hospital.

I am, Sir, yours truly,

Albany-street, N.W., June 26th, 1883. C. C. WHITEFOORD.

MINERAL WATERS IN FRANCE.

ACCORDING to a statement supplied by the Minister of Public Works to the Académie de Médecine, it appears that there are 1027 mineral springs in France, of which 357 are alkaline, 318 sulphureous, 215 saline, and 136 ferruginous. With regard to temperature, 641 are over 59°, and are classed as "thermal" springs, the rest being under and classed as cold springs. The departments which possess the most are the Puy-de-Dôme (Royat, Mont-Dore, &c.), with 94; the Ardèche (Vals), with 77; the Vosges (Plombières, Contrexéville, Luxieul, &c.), with 76; the Ariège (Aulus, Ax, Ussat, &c.) and the Pyrénées Orientales (Amélée-les-Bains, Le Boulou, Vernet and La Preste), with 69 each; and the Hautes-Pyrénées (Bagnères de Bigorre, Caprern, Cauterets, Barèges, St. Sauveur, &c.), with 64. The number of persons who took the waters in the Hautes-Pyrénées last season was 44,476, and the departments which received the next greatest number of bathers and drinkers were the Puy-de-Dôme (18,619), the Allier, in which is situated Vichy (16,430), the Haute-Garonne (14,220), and the Landes (12,954). The total outflow of all the mineral springs in France is estimated at 10,334 gallons per minute.

Mr. J. T. Lafan.—No. The more rapid the healing the less dense the cicatrix.

Anxious.—Either; but preferably a surgeon.

CASE OF BEAD-SWALLOWING.

To the Editor of THE LANCET.

SIR,—I send you the following case, thinking it may be of interest as showing both what a child may go through and what may go through a child without harm resulting.

On the evening of the 15th inst. I received an urgent message to go and see Mrs. S——'s child, who had "got something in its throat," and they were afraid it was choking. Putting a probang in my pocket, I quickly reached the house, and was astonished to find the child, a little thing eighteen months old, sitting in its mother's arms, and, except for a slight paleness, looking quite well. The mother's tale was to the effect that the child was sitting playing on the floor while she was washing, when suddenly it began to vomit. She immediately took it up, thinking it must have picked up something and swallowed it, as the vomiting came on so suddenly. Nothing but its food came up. None of the vomit was saved, so I had no chance of examining it. There was no difficulty of breathing or swallowing, and no pain on pressure over the stomach. I was inclined to think the mother mistaken as to the cause of the vomiting, but, as a precautionary measure, told her to feed it on dry food—biscuits and the like, and give it as little fluid as possible. The vomiting ceased, and no further symptoms declared themselves. On the following Monday, however, the child passed a somewhat hard motion, and with it a number of glass beads, well wrapped up in the motion. Again the bowels were moved and a like result; this time a bone button was passed as well. Very little pain was caused by the passage of these matters. The beads, when counted, numbered seventy. They are hexagonal-sided, measuring each about three-tenths to one-fourth of an inch in length, and about two-tenths of an inch in diameter—not large certainly, but numerous. The edges of the beads were sharp and ragged. The button is three-quarters of an inch in diameter, and is an ordinary horn coat button. The child, I am glad to say, has not experienced as yet (it is now a week ago) any bad effects from its curious, if ill-chosen, meal. When the child's age is taken into consideration (eighteen months), I think we may congratulate it on its safe deliverance from such indigestible materials as glass beads and coat-buttons. I am, Sir, your obedient servant,

Pocklington, Yorks, June 22nd, 1883. ARTHUR H. BOISSIER.

E. C. F.—Excision skilfully performed is undoubtedly preferable on all grounds to the cautery, potasse fusa, or any other caustic.

"PECULIAR DEPOSIT ON THE TONSIL."

To the Editor of THE LANCET.

SIR,—The description of a deposit on the tonsil, given by your correspondent, "Surgeon," agrees with that of an accumulation of secretion in an enlarged tonsiliar follicle,—a condition probably not uncommon, though seldom observed. I personally have been frequently troubled with it. Firm pressure, applied with a finger to the tonsil either above or below the deposit, will probably evacuate the secretion in the form of a cheesy pellet, leaving an unpleasant smell. If pressure alone be insufficient, I would recommend that the opening of the follicle be enlarged by a small incision. I am, Sir, yours truly,

June 27th, 1883. F. J. A.

LOCUM TENENS.

To the Editor of THE LANCET.

SIR,—A correspondent writes to a contemporary to inquire whether there is a medical agency in Ireland, through which locum tenens, assistants, &c., could be secured. As there is no such agency in Ireland, I shall be glad to furnish the names, &c., of several highly qualified gentlemen for such positions who, while awaiting appointment, are constantly reading in the library of this College.

I am, Sir, yours, &c.,

G. F. BLAKE,
Assistant Librarian, R.C.S.

Royal College of Surgeons, Dublin, July 4th, 1883.

TREES IN TOWNS.

THE question of the utility of trees in towns and cities was, it will be remembered, debated at the International Hygienic Congress held at Geneva last autumn, and has since been discussed with considerable spirit in the press of the city on the Rhone. The negative side has been supported with ability by Professor Piachaud, who favours the conclusions of the congress; Professor Gorot champions the affirmative side, and has, we think, much the best of the argument. Trees are useful in centres of population, not only in affording shade from the fierce heat of the sun, but in distributing moisture in dry weather through evaporation from their foliage, and in facilitating the drainage of the soil by means of their roots. The part played by trees in maintaining the equilibrium of the atmospheric gases is also of immense importance in crowded localities.

Dr. Vicaji.—We regret that we cannot insert our correspondent's letter, because we do not think he has stated the case correctly, and because the course he recommends for adoption would not, in our opinion, be advantageous to the medical school, the profession, or the public of Bombay.

"SCOTCH DIPLOMAS."

To the Editor of THE LANCET.

SIR,—I was not a little amused at the letter referring to Scotch diplomas, which appeared in THE LANCET of to-day. The writer, an alumnus of the Madras Medical College, and one of a very small number of medical men who look upon Scotch diplomas as equal to those obtained in London, asserts that in "the far-off East" the two are considered equally good; and he also declares that in some parts of the world the former are held to be the better.

In Bombay, however, the reverse is the case. Edinburgh diplomas are regarded as being far inferior to those obtainable at London, and the only students who betake themselves to the former place are those who are unsuccessful in the examination for the degree at the University of Bombay, and those who have managed to pass, but who have not distinguished themselves. The majority of the students who leave Bombay for Europe proceed to London, and of late years especially has this been the case, while those who pass with honours invariably go to London.

Of the fifteen students who passed the L. M. & S. examination last year, four (myself among them) have come to London, while a fifth will shortly be here, and a sixth a few months later. None have gone to Edinburgh or any other Scotch university, for we think that the degree obtained in Scotland is not a whit superior to the Bombay L. M. & S.

Further, I have made inquiries on this subject of people from Brazil, Canada, the United States, and the Cape of Good Hope, and they one and all declare that in all these places a medical man possessing London diplomas is considered far superior to one who has taken his degrees in Scotland, an opinion with which I am sure the majority of the readers of THE LANCET will heartily concur.—I am, Sir, yours, &c.,

June 24th, 1883. L. M. & S., Bombay.

A Birkenhead Resident.—Our correspondent does not give us any information. If the M.D. is not a British one, and the user of it has no registrable qualification, he lays himself open to an action.

W. J. J.—The Society for the Relief of Widows and Orphans of Medical Men, 53, Berners-street, W.

"INFANTILE CONSTIPATION."

To the Editor of THE LANCET.

SIR,—In your issue of the 30th ult., Mr. J. R. Seymour asks as to the feeding of a baby of two or three months old who suffers from constipation and its consequent derangements. I would suggest the trial of pepsine wine, about five drops given with each meal of milk and water. I have found it best to dilute the milk at first with twice its volume of water, sweeten with sugar of milk, and give the pepsine wine in a teaspoonful of the milk and water separately, either just at the commencement or in the middle of the meal. I have always found this abolish curdy stools and constipation in young children. An excellent account of the action of pepsine in stomach disorders of children will be found in the *Edinburgh Journal* of Nov. 1865, by Dr. Stephenson.

I am, Sir, yours faithfully,

Egham-hill, July 2nd, 1883. T. M. LOWNDS, M.D.

To the Editor of THE LANCET.

SIR,—I beg to suggest to Mr. Seymour for his case of obstinate infantile constipation that he should order milk diluted one half, and to each ordinary bottle add one or two teaspoonfuls of Dinneford's fluid magnesia. The abdomen should be well rubbed with oil two or three times daily, and night and morning one teaspoonful of cold water or more given if the infant will take it freely. During the first fortnight after the treatment is commenced it would be well to give each second night half a grain of leptandra.—I am, Sir, yours truly,

JOHN P. HAMILTON, M.D.

Elm House, Hawick, N.B., June 20th, 1883.

To the Editor of THE LANCET.

SIR,—In a case similar to Mr. Seymour's I found the compound liquorice powder supplied me by Messrs. Ferris and Co. most effective. The British Pharmacopœia formula I have found gripes too much.

I am, Sir, yours truly,

July 1st, 1883. H. A. L.

ADMISSION TO THE HOSPITALS OF PARIS.

HERETOFORE patients have not been received into the hospitals of Paris unless conveyed thither by the police, or unless admitted by order of the medical officers who make the regular morning visit. Consequently, patients who presented themselves in the afternoon were sent to the central office, whence they were obliged to make their way on foot to the particular hospital to which they might be assigned. A regulation has, however, been recently made which provides for the provisional reception of all applicants into any hospital at which they may present themselves, and in case of their subsequent assignment to another they will be conveyed to the latter in a vehicle. It has also been decided that the remnants of each day's meals are to be served to applicants the next morning, instead of being disposed of to a contractor, as in the past.

OATMEAL *v.* RICKETS.

To the Editor of THE LANCET.

SIR,—In your issue of last week Dr. Drewitt attributes rickets to the use of meal. Whilst heartily agreeing with the substance of his article as to the great value of condensed milk in the artificial dieting of children, I cannot but dissent from his views on the influence of meal, which, when properly prepared, I consider to be a most valuable food. Needless to say, this, like any other food when badly prepared and administered, may be incapable of maintaining health or life; but in such cases the symptoms are not those of rickets, but of simple marasmus, characterised by clean tongue, absence of fever, great craving for food, emaciation, and exhaustion. The period when children suffer from meal diet is in early infancy (first to eighth month). Rickets is most frequent after the twelfth month, and in very few cases, in my experience, is meal an element of their diet. Women in this part of the world need no caution against the use of meal. They apparently regard it as unfit for human food, being entirely ignorant how to cook it either for themselves or their children. There is abundant clinical proof that, properly prepared, meal is in many cases digestible from the earliest days of infancy; that it is capable of maintaining a child in robust health; that many children are reared on it with little or no milk; and that in many cases where cow's milk is rejected in every stage of dilution, the addition of a little well-cooked meal renders it perfectly digestible.

Finally, I do not believe that meal is ever directly concerned in the production of rickets, but that it is an important agent for the relief of that condition.—I am, Sir, yours truly,

ED. GEO. WHITTLE, M.D. Lond.,
Senior Surgeon to the Royal Alexandra Hospital for Children.

Dyke-road, Brighton, June 26th, 1883.

J. G.—The office of the Crown Agents for the Colonies, Downing-street, S.W.

Mr. John Woodland.—The hint has been frequently given in our columns.

SANITAS OIL IN PSORIASIS.

To the Editor of THE LANCET.

SIR,—In the face of so many different remedies, both external and internal, for the above complaint, I should hesitate to draw the attention of the profession to the value of another application were it not for the fact that most of the medicaments used for this complaint are the reverse of cleanly.

In a case of psoriasis of fifteen years' standing, where nearly every kind of treatment has been tried—including long courses of arsenic (which were injuring the patient's health), chrysophanic acid, tar ointment, turpentine, &c.—with only slight benefit, I was induced to try an ointment composed of vaseline, oxide of zinc, and sanitas oil, and was rewarded by a speedy removal of most of the patches of psoriasis, the usual brown discolouration of the skin, and a few small irritable spots alone remaining, which are disappearing under the same treatment, now continued for a month.

I suppose the *modus operandi* is similar to turpentine and like preparations, but sanitas oil has one very great advantage over other applications, and that is its cleanliness and freedom from disagreeable odour, and the fact that the linen of the patient is not stained or injured, which is a great consideration in private practice. Of course it is impossible to judge of the value of sanitas without extended trial, which I am unable to give at present, but I shall be very pleased if any member of the profession will give this drug a trial, and make known the result of treatment by this means.—Believe me, Sir, yours, &c.,

Gainsborough, June 24th, 1883. R. H. PATERSON, M.R.C.S., &c.

A WARNING.

To the Editor of THE LANCET.

SIR,—Kindly oblige by inserting the following; perhaps it may serve as a warning to other professional gentlemen who are in the habit of leaving their books lying about their consulting rooms. On Saturday morning whilst at breakfast some one entered my consulting-room and carried off my day and cash-book, for what purpose I know not. I may say that had it been an ordinary thief there were many things lying about which, in my opinion, were of more value to him than my books.

I remain, Sir, yours very truly,

WILLIAM ANTHONY HOPE.

St. Leonard's-road Provident Dispensary,
June 26th, 1883.

H. B. F.—Our correspondent is mistaken in supposing that we took no notice of his previous communication. If he will refer to p. 1076 of THE LANCET of June 16th he will find our acknowledgment under the pseudonym he adopted.

COMMUNICATIONS not noticed in our present number will receive attention in our next.

COMMUNICATIONS, LETTERS, &c., have been received from—Sir Henry Thompson, London; Dr. Dyce Duckworth, London; Dr. Thursfield, Shrewsbury; Dr. Watson, Tottenham; Dr. Burney Yeo, London; Dr. P. Johnston; Mr. W. D. Strang, Penge; Dr. Balthazar Foster, Birmingham; Mr. J. Woodland, London; Mr. T. F. Chavasse, Birmingham; Mr. Savory, London; Mr. J. O. Lane, Northampton; Mr. E. R. Williams, Liverpool; Mr. Chaumont, London; Mr. Pullin, Tunbridge Wells; Dr. Hardwick, Needham Market; Mr. H. Miller; Mr. Grosholz, Aberdovey; Dr. Austin, Tongue; Dr. H. B. Franklyn, London; Dr. Gavin Milroy, Richmond; Dr. H. B. Dow, London; Dr. Maurice G. Evans, Cardiff; Mr. Laffan, London; Dr. Seymour Sharkey, London; Mr. A. Smeal, Manchester; Dr. H. de Tatham, London; Mr. C. Davidson, London; Dr. Viccaji, Bombay; Dr. Laffan, Cashel; Mr. R. R. Allan, Maritzburg; Dr. Thin, London; Dr. Mair, Bayswater; Dr. J. Copland, Dunedin; Mr. W. Berry, Birmingham; Dr. J. C. Lucas, Ahmedabad; Mr. Hewitson, Leeds; Mr. Jeaffries, Eastbourne; Mr. Williams, Swansea; Mr. Whitstone, St. Andrews; Messrs. Charrington and Co., Colchester; Mr. M'Donald, Manchester; Mr. Birt, Crawley; Mr. Flint, Westgate; Mr. Hodgson; Mr. Russell, Liverpool; Dr. M'Adam, Edinburgh; Mr. Leaver, Stratford-on-Avon; Messrs. Ingram and Co., London; Mr. Johnson, Dudley; Mr. Willey, Birmingham; Mr. Etchett, Moreton-in-Marsh; Messrs. Barker and Sons, London; Dr. Davies, Newport; Mr. White Wallis, London; Mr. Gamgee, Birmingham; Miss Baker, Peckham; Mrs. Wright, London; Miss Gomme; Mr. Hyde, Buxton; Dr. Leonard Sedgwick, London; Dr. Imlach, Liverpool; Messrs. Forder and Co., Wolverhampton; Mr. Batt, Falmouth; Dr. Bristowe, London; Mr. Blake, Dublin; A Birkenhead Resident; A Retired Brigade Surgeon; E. C., Fulham; J. W.; Ferrum; S. M. D.; H. E.; M.R.C.S.; D. S.; E. C. F.; G. H. H.; X., Dundee; Lex; Anxious; L.R.C.P. Lond.; Enquirer; W. J. I.; &c., &c.

LETTERS, each *with enclosure*, are also acknowledged from—Dr. Wood, Burton-on-Trent; Rev. A. J. D'Orsey, London; Dr. Davies, Sandbach; Mrs. Harris, Kendal; Mr. Hoare, Water Newton; Mr. Bullivant, Derby; Mr. Horne; Mr. Pope, Bandon; Mr. Rooke, Padstowe; Dr. Ellis, Eastbourne; Dr. Cane, Peterboro'; Mr. Boileau, Paris; Miss Hankey, Hayward's-heath; Dr. Balbisnie, Staveley; Mr. Gilkes, Hereford; Mr. Leaver, Stratford-on-Avon; Dr. T. Cooke, London; Mr. Browne, West Bromwich; Mr. Williams, Liverpool; Mr. Buckby, Brixton; Messrs. Wyman and Co., London; Messrs. Reynolds and Branson, Leeds; Dr. Macadam, Edinburgh; Mr. Hunt, Longbridge; Mr. Clough, Hambledon; Dr. Potts, Bridge of Allan; Dr. Harris, Dalston; Messrs. Bleech and Leech, Bath; Mr. Saunderson, Bury; Mr. Taylor, Paisley; Mr. George, Bristol; Dr. Edwardson, Calcutta; Mr. Parkinton, Tunbridge Wells; Messrs. Porteous and Co., Glasgow; Mr. Butler, Toddington; Dr. Poulson, Loughboro'; Mr. Abbott, Sheffield; Mrs. Borne; Dr. Branfoot, Madras; M.D., Bradford; Interview; Glacus; A. B., Glasgow; Forceps, Peel; Neptune; J. F., Melksham; Medicus, Stamford; Faber; Immediate; H. & H., Hull; Medicus, London; H. S. O.; L. T. N.; H. W. B.; M.D., Birmingham; L. T.; W. T. T., Liverpool; E. A. S.; Goole; M. F.; Principal, St. Leonards; F. F. J., Slough; &c., &c.

Kentish Express, Alliance News, Cosey Public-house News, Reading Express, Western Mail, Ulverston Mirror, City Press, Kent and Sussex Courier, Hackney Express, Brighton Guardian, Health, &c., have been received.

Medical Diary for the ensuing Week.

Monday, July 9.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10½ A.M. each day, and at the same hour.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1½ P.M. each day, and at the same hour.

METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.

ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.

ST. MARK'S HOSPITAL.—Operations, 2 P.M.; on Tuesday, 9 A.M.

HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M., and on Thursday at the same hour.

Tuesday, July 10.

GUY'S HOSPITAL.—Operations, 1½ P.M., and on Friday at the same hour.

WESTMINSTER HOSPITAL.—Operations, 2 P.M.

WEST LONDON HOSPITAL.—Operations, 2.30 P.M.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Dr. Garson, "On the Circulatory System of Reptiles (venous system).

Wednesday, July 11.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.

MIDDLESEX HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.—Ophthalmic Operations on Tuesdays and Thursdays, at 1.30 P.M.

ST. MARY'S HOSPITAL.—Operations, 1½ P.M.

ST. THOMAS'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.

LONDON HOSPITAL.—Operations, 2 P.M., and on Thursday and Saturday at the same hour.

GREAT NORTHERN HOSPITAL.—Operations, 2 P.M.

SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2½ P.M.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at the same hour.—Skin Department: 1.45 P.M., and on Saturday at 9.15 A.M.

Thursday, July 12.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—1½ P.M. Surgical Consultations.

CHARING-CROSS HOSPITAL.—Operations, 2 P.M.

CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and on Friday at the same hour.

NORTH-WEST LONDON HOSPITAL.—Operations, 2½ P.M.

THE PARKES MUSEUM OF HYGIENE.—8 P.M. Dr. Charles Henry Ralfe, "On the Hygiene of Schools."

Friday, July 13.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1½ P.M.

ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 2 P.M.

ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.

KING'S COLLEGE HOSPITAL.—Operations, 2 P.M.

Saturday, July 14.

KING'S COLLEGE HOSPITAL.—Operations, 1 P.M.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.

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